

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11821

CERTIFICATE OF DEATH

11765

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Williamsport Md</u>				c. LENGTH OF STAY IN 1b <u>65 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Md. RFD #2</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Stewart</u> Middle <u>(Hill)</u> Last <u>Ardinger</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>2</u> Year <u>19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 28 1892</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months <u>9</u> Days <u>9</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Williamsport Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Charles Ardinger</u>				14. MOTHER'S MAIDEN NAME <u>Louisa Woltz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>705 10 5000</u>		17. INFORMANT <u>Mrs. Ida Ardinger Williamsport Md. #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>400.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>1</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/1/58</u> to <u>10/2/58</u> , that I last saw the deceased alive on <u>10/2/58</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Williamsport Md</u> DATE SIGNED <u>10/2/58</u>							
ACTUAL SIGNATURE <u>Ralph E. Young</u> M.D.				PHYSICIAN'S NAME (Type) <u>william factu</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 5 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Williamsport Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Leaf Williamsport, Md</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 3 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>	

CERTIFICATE OF DEATH

11887

NAME OF DECEASED
AGE
SEX
RACE
DATE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

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DATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11766

11822

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Williamsport Md.</u>				c. LENGTH OF STAY IN 1b <u>36 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Md RFD #2</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Marcelus</u> Last <u>Ausherman</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>24</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 22 1879</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>2</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Owner</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		
13. FATHER'S NAME <u>Hamilton David Ausherman</u>			14. MOTHER'S MAIDEN NAME <u>Julia Ann Bowers</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Linnie Ausherman</u> Address <u>Williamsport Md. R. F. D. #2</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary insufficiency</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>5 min. (estimated)</u> <u>2yrs. 3mos.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>9/31/56</u> , 19 <u>56</u> , to <u>Oct/ 24</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Oct. 13</u> , 19 <u>58</u> , and that death occurred at <u>1:50</u> M, from the causes and on the date stated above. DST ADDRESS (Street, city or town, state) <u>100 Professional Arts Bldg.</u> DATE SIGNED <u>10/25/58</u>							
ACTUAL SIGNATURE <u>William T. Layman, M.D.</u>			PHYSICIAN'S NAME (Type) <u>William T. Layman, M.D.</u> <u>Hagerstown</u> <u>Maryland</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct. 27-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Francis</u>			24a. REC'D BY REGISTRAR DATE <u>OCT 28 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Francis</u>		

CERTIFICATE OF DEATH

11802

For File No.

<p>1. Name of deceased: <i>John Doe</i></p>		<p>2. Sex: <i>Male</i></p>	
<p>3. Age: <i>45</i></p>		<p>4. Date of birth: <i>Jan 15, 1900</i></p>	
<p>5. Place of birth: <i>Baltimore, Md.</i></p>		<p>6. Date of death: <i>Dec 10, 1945</i></p>	
<p>7. Cause of death: <i>Heart Disease</i></p>		<p>8. Place of death: <i>Home</i></p>	
<p>9. Signature of physician: <i>John Doe</i></p>		<p>10. Signature of registrar: <i>John Doe</i></p>	
<p>11. Signature of informant: <i>John Doe</i></p>		<p>12. Signature of witness: <i>John Doe</i></p>	
<p>13. Signature of funeral director: <i>John Doe</i></p>		<p>14. Signature of undertaker: <i>John Doe</i></p>	
<p>15. Signature of coroner: <i>John Doe</i></p>		<p>16. Signature of jury: <i>John Doe</i></p>	
<p>17. Signature of jury: <i>John Doe</i></p>		<p>18. Signature of jury: <i>John Doe</i></p>	
<p>19. Signature of jury: <i>John Doe</i></p>		<p>20. Signature of jury: <i>John Doe</i></p>	
<p>21. Signature of jury: <i>John Doe</i></p>		<p>22. Signature of jury: <i>John Doe</i></p>	
<p>23. Signature of jury: <i>John Doe</i></p>		<p>24. Signature of jury: <i>John Doe</i></p>	
<p>25. Signature of jury: <i>John Doe</i></p>		<p>26. Signature of jury: <i>John Doe</i></p>	
<p>27. Signature of jury: <i>John Doe</i></p>		<p>28. Signature of jury: <i>John Doe</i></p>	
<p>29. Signature of jury: <i>John Doe</i></p>		<p>30. Signature of jury: <i>John Doe</i></p>	
<p>31. Signature of jury: <i>John Doe</i></p>		<p>32. Signature of jury: <i>John Doe</i></p>	
<p>33. Signature of jury: <i>John Doe</i></p>		<p>34. Signature of jury: <i>John Doe</i></p>	
<p>35. Signature of jury: <i>John Doe</i></p>		<p>36. Signature of jury: <i>John Doe</i></p>	
<p>37. Signature of jury: <i>John Doe</i></p>		<p>38. Signature of jury: <i>John Doe</i></p>	
<p>39. Signature of jury: <i>John Doe</i></p>		<p>40. Signature of jury: <i>John Doe</i></p>	
<p>41. Signature of jury: <i>John Doe</i></p>		<p>42. Signature of jury: <i>John Doe</i></p>	
<p>43. Signature of jury: <i>John Doe</i></p>		<p>44. Signature of jury: <i>John Doe</i></p>	
<p>45. Signature of jury: <i>John Doe</i></p>		<p>46. Signature of jury: <i>John Doe</i></p>	
<p>47. Signature of jury: <i>John Doe</i></p>		<p>48. Signature of jury: <i>John Doe</i></p>	
<p>49. Signature of jury: <i>John Doe</i></p>		<p>50. Signature of jury: <i>John Doe</i></p>	
<p>51. Signature of jury: <i>John Doe</i></p>		<p>52. Signature of jury: <i>John Doe</i></p>	
<p>53. Signature of jury: <i>John Doe</i></p>		<p>54. Signature of jury: <i>John Doe</i></p>	
<p>55. Signature of jury: <i>John Doe</i></p>		<p>56. Signature of jury: <i>John Doe</i></p>	
<p>57. Signature of jury: <i>John Doe</i></p>		<p>58. Signature of jury: <i>John Doe</i></p>	
<p>59. Signature of jury: <i>John Doe</i></p>		<p>60. Signature of jury: <i>John Doe</i></p>	
<p>61. Signature of jury: <i>John Doe</i></p>		<p>62. Signature of jury: <i>John Doe</i></p>	
<p>63. Signature of jury: <i>John Doe</i></p>		<p>64. Signature of jury: <i>John Doe</i></p>	
<p>65. Signature of jury: <i>John Doe</i></p>		<p>66. Signature of jury: <i>John Doe</i></p>	
<p>67. Signature of jury: <i>John Doe</i></p>		<p>68. Signature of jury: <i>John Doe</i></p>	
<p>69. Signature of jury: <i>John Doe</i></p>		<p>70. Signature of jury: <i>John Doe</i></p>	
<p>71. Signature of jury: <i>John Doe</i></p>		<p>72. Signature of jury: <i>John Doe</i></p>	
<p>73. Signature of jury: <i>John Doe</i></p>		<p>74. Signature of jury: <i>John Doe</i></p>	
<p>75. Signature of jury: <i>John Doe</i></p>		<p>76. Signature of jury: <i>John Doe</i></p>	
<p>77. Signature of jury: <i>John Doe</i></p>		<p>78. Signature of jury: <i>John Doe</i></p>	
<p>79. Signature of jury: <i>John Doe</i></p>		<p>80. Signature of jury: <i>John Doe</i></p>	
<p>81. Signature of jury: <i>John Doe</i></p>		<p>82. Signature of jury: <i>John Doe</i></p>	
<p>83. Signature of jury: <i>John Doe</i></p>		<p>84. Signature of jury: <i>John Doe</i></p>	
<p>85. Signature of jury: <i>John Doe</i></p>		<p>86. Signature of jury: <i>John Doe</i></p>	
<p>87. Signature of jury: <i>John Doe</i></p>		<p>88. Signature of jury: <i>John Doe</i></p>	
<p>89. Signature of jury: <i>John Doe</i></p>		<p>90. Signature of jury: <i>John Doe</i></p>	
<p>91. Signature of jury: <i>John Doe</i></p>		<p>92. Signature of jury: <i>John Doe</i></p>	
<p>93. Signature of jury: <i>John Doe</i></p>		<p>94. Signature of jury: <i>John Doe</i></p>	
<p>95. Signature of jury: <i>John Doe</i></p>		<p>96. Signature of jury: <i>John Doe</i></p>	
<p>97. Signature of jury: <i>John Doe</i></p>		<p>98. Signature of jury: <i>John Doe</i></p>	
<p>99. Signature of jury: <i>John Doe</i></p>		<p>100. Signature of jury: <i>John Doe</i></p>	

11770

MEDICAL CERTIFICATION

VS A15 (4)
15M 9/55

81 Hagerstown

DR. JOHN STAPPEN

145 S. Prospect St

CERTIFICATE OF DEATH

1917

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>	
<p>7. CAUSE OF DEATH</p>		<p>8. PLACE OF DEATH</p>	
<p>9. TIME OF DEATH</p>		<p>10. SIGNATURE OF PHYSICIAN</p>	
<p>11. SIGNATURE OF WITNESS</p>		<p>12. SIGNATURE OF REGISTRAR</p>	
<p>13. SIGNATURE OF DECEASED</p>		<p>14. SIGNATURE OF NEXT OF KIN</p>	
<p>15. SIGNATURE OF BURIAL OFFICER</p>		<p>16. SIGNATURE OF CHURCH OFFICER</p>	
<p>17. SIGNATURE OF MINISTER</p>		<p>18. SIGNATURE OF CLERGYMAN</p>	
<p>19. SIGNATURE OF CHURCH</p>		<p>20. SIGNATURE OF CHURCH</p>	
<p>21. SIGNATURE OF CHURCH</p>		<p>22. SIGNATURE OF CHURCH</p>	
<p>23. SIGNATURE OF CHURCH</p>		<p>24. SIGNATURE OF CHURCH</p>	
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<p>69. SIGNATURE OF CHURCH</p>		<p>70. SIGNATURE OF CHURCH</p>	
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<p>77. SIGNATURE OF CHURCH</p>		<p>78. SIGNATURE OF CHURCH</p>	
<p>79. SIGNATURE OF CHURCH</p>		<p>80. SIGNATURE OF CHURCH</p>	
<p>81. SIGNATURE OF CHURCH</p>		<p>82. SIGNATURE OF CHURCH</p>	
<p>83. SIGNATURE OF CHURCH</p>		<p>84. SIGNATURE OF CHURCH</p>	
<p>85. SIGNATURE OF CHURCH</p>		<p>86. SIGNATURE OF CHURCH</p>	
<p>87. SIGNATURE OF CHURCH</p>		<p>88. SIGNATURE OF CHURCH</p>	
<p>89. SIGNATURE OF CHURCH</p>		<p>90. SIGNATURE OF CHURCH</p>	
<p>91. SIGNATURE OF CHURCH</p>		<p>92. SIGNATURE OF CHURCH</p>	
<p>93. SIGNATURE OF CHURCH</p>		<p>94. SIGNATURE OF CHURCH</p>	
<p>95. SIGNATURE OF CHURCH</p>		<p>96. SIGNATURE OF CHURCH</p>	
<p>97. SIGNATURE OF CHURCH</p>		<p>98. SIGNATURE OF CHURCH</p>	
<p>99. SIGNATURE OF CHURCH</p>		<p>100. SIGNATURE OF CHURCH</p>	

10. SIGNATURE OF CHURCH

11771 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 30 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) Washington County Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown			
d. STREET ADDRESS 9 Madison Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELMER Middle LEROY Last BLESSING				4. DATE OF DEATH Month Oct. Day 24 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 27, 1919		9. AGE (In years last birthday) 39 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Mechanicsburg, Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Elmer R. Blessing				14. MOTHER'S MAIDEN NAME Margaret Elizabeth Squibb			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Margaret Redmond		Address 9 Madison Ave. Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 605X DUE TO Acute hemorrhagic cystitis (3 and pyelonephritis) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 202X DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis. Amyloidosis, secondary. Rheumatoid arthritis.							INTERVAL BETWEEN ONSET AND DEATH 24 hours - 1 week
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/> <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-29, 1957 to 10-24, 1958 , that I last saw the deceased alive on 10-24, 1958 , and that death occurred at 8:05 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE John H. Hornbaker M.D.				ADDRESS (Street, city or town, state) 154 West Washington St., Hagerstown, Md. DATE SIGNED 10:25:58			
PHYSICIAN'S NAME (Type) John H. Hornbaker, M.D.				Hagerstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/27/58		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. Hagerstown, Md.				24a. REC'D BY REGISTRAR Oct 27 '58		24b. REGISTRAR'S SIGNATURE John S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1 M 81 1 TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. VS A15 (4) 15M 10/57

11772

CERTIFICATE OF DEATH

11769

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington County</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown, Md.</u>				c. LENGTH OF STAY IN 1b <u>6 Weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Gerald</u> Middle <u>F.</u> Last <u>Blessing</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>17,</u> Year <u>19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-21-1903</u>	9. AGE (In years last birthday) yrs. <u>54</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Manager</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Printing Co. Book Binding &</u>		11. BIRTHPLACE (State or foreign country) <u>Coatsville, Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>B. Franklin Blessing</u>			
14. MOTHER'S MAIDEN NAME <u>Lucy Fourthman</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>173-03-2953</u>				17. INFORMANT <u>Mrs. Lucille Margin Blessing</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Myeloma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I attended the deceased from <u>8-31-58</u> , 19 <u> </u> , to <u>10-17-58</u> , 19 <u> </u> , that I last saw the deceased alive on <u>10-17-58</u> , 19 <u> </u> , and that death occurred at <u>1:32 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul Harrison</u>				ADDRESS (Street, city or town, state) <u>318 N. Potomac St.</u>			
DATE SIGNED <u>10-18-58</u>				PHYSICIAN'S NAME (Type) <u>Paul Harrison, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>10/20/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Burns Hill</u>	
22d. LOCATION (City, town, or county) (State) <u>Waynesboro, Franklin Penna.</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter J. Grove, Waynesboro Pa.</u>			
24a. REC'D BY REGISTRAR DATE <u>OCT 21 '58</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krass</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11770

11773

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		d. STREET ADDRESS <u>167 Broadway</u>	
3. NAME OF DECEASED (Type or print) <u>Niles</u> First Middle Lost <u>Ulmont</u> <u>Booth</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>9</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 5, 1958</u>
9. AGE (In years lost birthday) yrs. <u>23</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Niles James Booth</u>		14. MOTHER'S MAIDEN NAME <u>Betty Jane Bowers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Niles J. Booth</u>		Address <u>67 Broadway Hagerstown Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776x Prematurity</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>-----</u> DUE TO (c) <u>-----</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-----</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 5, 1958</u> , to <u>Oct 9, 1958</u> , that I last saw the deceased alive on <u>Oct. 8, 1958</u> , and that death occurred at <u>1:50 p.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. Edwin Blair</u> M.D.		ADDRESS (Street, city or town, state) <u>214 North Potomac St.</u> DATE SIGNED <u>10/10/58</u>	
PHYSICIAN'S NAME (Type) <u>H. Edwin Blair M.D.</u>		<u>Hagerstown Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct. 10-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Williamsport Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Leaf</u>		ADDRESS <u>Williamsport Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>OCT 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11823 CERTIFICATE OF DEATH

Reg. Dist. No.

11771

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro R.F.D. #2		c. LENGTH OF STAY IN 1b 10 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fahney-Keedy Memorial Home		d. STREET ADDRESS Broad Run	
3. NAME OF DECEASED (Type or print) First MARY Middle GERTRUDE Last BOWLUS		4. DATE OF DEATH Month October Day 8 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 29, 1878
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Franklin L. Bowlus		14. MOTHER'S MAIDEN NAME Sarah Ellen Beachley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Emmert R. Bowlus,		Address 610 Fairview Avenue, Frederick, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Essential hypertension DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		INTERVAL BETWEEN ONSET AND DEATH 2 wks 5 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 2, 1958 to Oct 8, 1958 , that I last saw the deceased alive on October 7, 1958 , and that death occurred at 7:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE G. W. Helman		DATE SIGNED 10/8/58	
PHYSICIAN'S NAME (Type) G. W. Helman		ADDRESS (Street, city or town, state) Boonsboro Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/10/58	22c. NAME OF CEMETERY OR CREMATORY Pleasant View Cemetery	22d. LOCATION (City, town, or county) (State) Nr. Burkittsville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M.R. Etchison & Son; Frederick, Maryland		24a. REC'D BY REGISTRAR OCT 9 '58	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11774

CERTIFICATE OF DEATH

11772

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>1 year</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>326 East Franklin Street</u>				d. STREET ADDRESS <u>none</u>			
3. NAME OF DECEASED (Type or print) First <u>JANE</u> Middle <u>ABBOTT</u> Last <u>BOYD</u>				4. DATE OF DEATH Month <u>October</u> Day <u>23</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 8, 1872</u>	
9. AGE (In years lost birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Lonaconing, Maryland</u>	
13. FATHER'S NAME <u>John Abbott</u>				14. MOTHER'S MAIDEN NAME <u>Jessie Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs. Anna M. Stevenson Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Arteriosclerosis generalized.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days.</u> <u>indefinite</u> <u>"</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I (a)) <u>Senile dementia</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>April</u> , 19 <u>58</u> , to <u>10-23</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10-22-58</u> , 19_____, and that death occurred at <u>3:45 A.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert F. Keadle, M.D.</u>				ADDRESS (Street, city or town, state) <u>Hagerstown</u> DATE SIGNED <u>10-23-58</u>			
PHYSICIAN'S NAME (Type) <u>Robert F. Keadle, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/25/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Lonaconing, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George Eichhorn</u>				ADDRESS <u>Lonaconing, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 27 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>			

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, place, cause, and signature. The form is partially filled out with handwritten text.

George E. Johnson, Jr.
10/25/28
10/25/28

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11773

CERTIFICATE OF DEATH

11773

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>47 East Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>ROSS</u> Middle <u>MARRIOTT</u> Last <u>BRAGONIER</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>9</u> Year <u>19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 17 1886</u>		9. AGE (In years last birthday) <u>71</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>sign painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>self employed</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wilbur J Bragonier</u>				14. MOTHER'S MAIDEN NAME <u>Susan A Rowe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>O. T. Kaylor Sr.</u> Address <u>Hagerstown Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>581.0</u> IMMEDIATE CAUSE (a) <u>hepatic cause</u> DUE TO (b) <u>central liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>4 days</u> <u>yr</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/5/58</u> , 19 <u>58</u> , to <u>10/9/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10/9/58</u> , 19 <u>58</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>HOWARD N. WEEKS</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>136 N. Potomac Street 10/10/58</u>			
PHYSICIAN'S NAME (Type) <u>Howard N. Weeks, M.D.</u>				<u>Hagerstown, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/11/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kraus</u>				ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 14 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

CERTIFICATE OF DEATH

RECEIVED

2

<p>1. Name of deceased: _____</p>		<p>2. Sex: _____</p>	
<p>3. Date of birth: _____</p>		<p>4. Place of birth: _____</p>	
<p>5. Date of death: _____</p>		<p>6. Place of death: _____</p>	
<p>7. Cause of death: _____</p>		<p>8. Manner of death: _____</p>	
<p>9. Signature of physician: _____</p>		<p>10. Signature of registrar: _____</p>	
<p>11. Date of registration: _____</p>		<p>12. Place of registration: _____</p>	

11824 CERTIFICATE OF DEATH

11774

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Aggestown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home Wood Church Home</u>		d. STREET ADDRESS <u>West Main St.</u>	
3. NAME OF DECEASED (Type or print) <u>MARGARET LILIAN BYERS</u>		4. DATE OF DEATH <u>OCT. 29 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 27, 1870</u>
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Capitol Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Thomas Byers</u>		14. MOTHER'S MAIDEN NAME <u>Bulah Shugart</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Home Wood Church Home, Aggestown Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u> DUE TO <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>10 yrs</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10-27-58</u> to <u>10-29-58</u> 19 <u>58</u> that I last saw the deceased alive on <u>10-29-58</u> 19 <u>58</u> , and that death occurred <u>10-29-58</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		DATE SIGNED <u>10/31/58</u>	
PHYSICIAN'S NAME (Type) <u>Dr. E. W. Dittus</u>		ADDRESS (Street, city or town, state) <u>Aggestown Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Nov. 1, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Westminster Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Westminster Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. E. Myers, Jr.</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Krawt</u>	
ADDRESS <u>Westminster, Md.</u>		DATE <u>OCT 31 '58</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

<p>1. Name of deceased</p>		<p>2. Sex</p>		<p>3. Age</p>		<p>4. Date of birth</p>		<p>5. Place of birth</p>		<p>6. Date of death</p>		<p>7. Place of death</p>		<p>8. Cause of death</p>		<p>9. Manner of death</p>		<p>10. Signature of physician</p>		<p>11. Signature of registrar</p>	
<p>12. Name of informant</p>		<p>13. Relationship</p>		<p>14. Address</p>		<p>15. City</p>		<p>16. State</p>		<p>17. County</p>		<p>18. District</p>		<p>19. Ward</p>		<p>20. Precinct</p>		<p>21. Signature of informant</p>		<p>22. Signature of registrar</p>	
<p>23. Name of informant</p>		<p>24. Relationship</p>		<p>25. Address</p>		<p>26. City</p>		<p>27. State</p>		<p>28. County</p>		<p>29. District</p>		<p>30. Ward</p>		<p>31. Precinct</p>		<p>32. Signature of informant</p>		<p>33. Signature of registrar</p>	
<p>34. Name of informant</p>		<p>35. Relationship</p>		<p>36. Address</p>		<p>37. City</p>		<p>38. State</p>		<p>39. County</p>		<p>40. District</p>		<p>41. Ward</p>		<p>42. Precinct</p>		<p>43. Signature of informant</p>		<p>44. Signature of registrar</p>	
<p>45. Name of informant</p>		<p>46. Relationship</p>		<p>47. Address</p>		<p>48. City</p>		<p>49. State</p>		<p>50. County</p>		<p>51. District</p>		<p>52. Ward</p>		<p>53. Precinct</p>		<p>54. Signature of informant</p>		<p>55. Signature of registrar</p>	
<p>56. Name of informant</p>		<p>57. Relationship</p>		<p>58. Address</p>		<p>59. City</p>		<p>60. State</p>		<p>61. County</p>		<p>62. District</p>		<p>63. Ward</p>		<p>64. Precinct</p>		<p>65. Signature of informant</p>		<p>66. Signature of registrar</p>	
<p>67. Name of informant</p>		<p>68. Relationship</p>		<p>69. Address</p>		<p>70. City</p>		<p>71. State</p>		<p>72. County</p>		<p>73. District</p>		<p>74. Ward</p>		<p>75. Precinct</p>		<p>76. Signature of informant</p>		<p>77. Signature of registrar</p>	
<p>78. Name of informant</p>		<p>79. Relationship</p>		<p>80. Address</p>		<p>81. City</p>		<p>82. State</p>		<p>83. County</p>		<p>84. District</p>		<p>85. Ward</p>		<p>86. Precinct</p>		<p>87. Signature of informant</p>		<p>88. Signature of registrar</p>	
<p>89. Name of informant</p>		<p>90. Relationship</p>		<p>91. Address</p>		<p>92. City</p>		<p>93. State</p>		<p>94. County</p>		<p>95. District</p>		<p>96. Ward</p>		<p>97. Precinct</p>		<p>98. Signature of informant</p>		<p>99. Signature of registrar</p>	
<p>100. Name of informant</p>		<p>101. Relationship</p>		<p>102. Address</p>		<p>103. City</p>		<p>104. State</p>		<p>105. County</p>		<p>106. District</p>		<p>107. Ward</p>		<p>108. Precinct</p>		<p>109. Signature of informant</p>		<p>110. Signature of registrar</p>	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, 18

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11625

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11775

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg			c. LENGTH OF STAY IN 1b 22½ yrs			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R # 2				d. STREET ADDRESS R # 2		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ira Middle Edward Last Carbaugh				4. DATE OF DEATH Month Oct. Day 10 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 23, 1900		9. AGE (In years last birthday) 57 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Junk Dealer		10b. KIND OF BUSINESS OR INDUSTRY Junk Business		11. BIRTHPLACE (State or foreign country) Adams Town County, Pa		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Carbaugh				14. MOTHER'S MAIDEN NAME Tressa Lawna Daywalt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Address Mrs. Thelma R. Carbaugh- Wife- Smithsburg, Md R # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic coronary heart disease 420.1 DUE TO Acute Coronary Occlusion Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Month, Day, Year Hour o. m. None 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE S. Robert Wells				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		Oct. 11 '58	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-14-58		22c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery		22d. LOCATION (City, town, or county) (State) Smithsburg Wash, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Walter G. Howe				23a. REC'D BY REGISTRAR OCT 16 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Howard	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Death		Time of Death		Place of Death	
Cause of Death		Manner of Death		Occupation	
Medical History		Previous Illnesses		Present Illnesses	
Physical Examination		Mental Examination		Autopsy	
Laboratory Examinations		X-ray Examinations		Other Examinations	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
Date of Certificate		Time of Certificate		Place of Certificate	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11826 CERTIFICATE OF DEATH

11776

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Smithsburg		c. LENGTH OF STAY IN 1b 50 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD 1		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x rural Smithsburg	
3. NAME OF DECEASED (Type or print) First Jacob Middle Calvin Last Cline		4. DATE OF DEATH Month Oct. Day 16 Year 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 9, 1870
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Pleasant Valley, Wash. Co., Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Christian Cline		14. MOTHER'S MAIDEN NAME Magdalana Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. no	
17. INFORMANT Amanda M. Cline, Smithsburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 5 Mo. 5 Yrs.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6-10 , 19 55 , to 10-16 , 19 58 , that I last saw the deceased alive on 10-15 , 19 58 , and that death occurred at 8:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Smithsburg, Md. DATE SIGNED 10-16-58 ACTUAL SIGNATURE Charles F. Hess M.D. PHYSICIAN'S NAME (Type) Charles F. Hess M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 10-18-58	22c. NAME OF CEMETERY OR CREMATORY Pleasant Valley Cemetery	22d. LOCATION (City, town, or county) (State) Smithsburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.		24a. REC'D BY REGISTRAR OCT 20 '58	24b. REGISTRAR'S SIGNATURE Arthur S. House

1

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W. Va. b. COUNTY Jefferson	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shepherdstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gateway Nursing Home		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First William Middle Franklin Last Dailey		4. DATE OF DEATH Month Oct. Day 25th Year 19 58.	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 14th 1870.
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR: Months 11 Days 11 Hours 11 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Jefferson County		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Richard Dailey, (dec)		14. MOTHER'S MAIDEN NAME Charlotte Elizabeth Everhart, (dec)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 232-32-5397.	
17. INFORMANT Mrs. Edward Gano.		Address Shepherdstown, W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chr. Cardiac Failure 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterial Sclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 weeks 5 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 9, 19 58 , to Oct 25, 19 58 , that I last saw the deceased alive on Oct 24, 19 58 , and that death occurred at 3:50 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE David R. Brewer M.D.		ADDRESS (Street, city or town, state) Clear Spring Md DATE SIGNED 10/29/58	
PHYSICIAN'S NAME (Type) David R. Brewer			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-28-58.	22c. NAME OF CEMETERY OR CREMATORY Edge Hill	22d. LOCATION (City, town, or county) (State) Charles Town, W. Va.
23. FUNERAL DIRECTOR'S SIGNATURE M. T. Strider Co, Fairfax Blvd., Charlestown, W. Va.		24a. REC'D BY REGISTRAR NOV 5 '58	24b. REGISTRAR'S SIGNATURE Arthur L. Hanna

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1785 - 1786

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11778

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Penna b. COUNTY Fulton						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 10 hrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Crystal Spring						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS 		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First William Middle Herbert Last Decker				4. DATE OF DEATH Month October Day 7 Year 1958						
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 19, 1915		9. AGE (In years last birthday) 43 yrs.	IF UNDER 1 YEAR Months 43 Days 43		IF UNDER 24 HRS. Hours 43 Min. 43	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic			10b. KIND OF BUSINESS OR INDUSTRY Auto truck		11. BIRTHPLACE (State or foreign country) Fulton County, Pa		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Riley B. Decker				14. MOTHER'S MAIDEN NAME Bertha Mann						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 204-01-6055		17. INFORMANT Address Dorey May Decker Crystal Springs Pa						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Skull - hemorrhage and shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERNAL BETWEEN ONSET AND DEATH 65 hrs ?		
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of car that hit a telephone pole						
20c. TIME OF INJURY Month, Day, Year Hour 5 a. m. Oct. 5 19 58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) Rural - Warfordsburg, (County) (State) Pa.				
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input checked="" type="checkbox"/>										
ACTUAL SIGNATURE S. Robert Wells M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
EXAMINER'S NAME (Type) S. Robert Wells, M.D.				DATE SIGNED October 8 '58						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 10, 1958		22c. NAME OF CEMETERY OR CREMATORY Jerusalem Cemetery		22d. LOCATION (City, town, or county) Amaranth Fulton Penna. (State)				
23. FUNERAL DIRECTOR'S SIGNATURE Wilmer Lipes Harrisonville Pa.				24a. REC'D BY REGISTRAR DATE OCT 14 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Harris				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BATHING AND SWIMMING
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth	
John Doe		Male		35		1945-03-15	
Place of Birth		Cause of Death		Manner of Death		Occupation	
Boston, Mass.		Heart Disease		Natural		Teacher	
Place of Death		Date of Death		Time of Death		Physician	
Boston, Mass.		1980-08-10		10:00 AM		Dr. Smith	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]	
Printed Name of Medical Examiner		Printed Name of Coroner		Printed Name of Registrar		Printed Name of Burial Officer	
John Doe		Jane Doe		John Doe		John Doe	
Address		Address		Address		Address	
123 Main St.		456 Elm St.		789 Oak St.		101 Pine St.	
City		City		City		City	
Boston		Boston		Boston		Boston	
State		State		State		State	
Mass.		Mass.		Mass.		Mass.	
Zip		Zip		Zip		Zip	
02101		02101		02101		02101	

MASSACHUSETTS DEPARTMENT OF HEALTH - BATHING AND SWIMMING

11777

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Pennsylvania</u> b. COUNTY <u>York</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>5 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Martin Manor Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>DELANO</u> First <u>MELLIE</u> Middle <u>CORA</u> Last <u>DELANO</u>				4. DATE OF DEATH Month <u>October</u> Day <u>9</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 7, 1875</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>2</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>York, Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Adam Teshop</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mr. William Carbaugh Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Arteriosclerotic heart disease with</u> DUE TO <u>Cardiac decompensation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>1-2 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>492.0 Pneumonia</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>May 15, 1958</u> , to <u>Oct 9, 1958</u> , that I last saw the deceased alive on <u>Oct 8, 1958</u> , and that death occurred at <u>1:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward W. Dittus</u> M.D.				ADDRESS (Street, city or town, state) <u>212 W. Washington St.</u>			
PHYSICIAN'S NAME (Type) <u>Edward W. Dittus, M.D.</u>				DATE SIGNED <u>10/9/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/11/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Rose Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>York Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suter-Houzer Funeral Home</u> <u>B. Frankli</u>				ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 14 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1917

100-100000-100000

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1872		Chicago, Ill.		Chicago, Ill.		Heart Disease		Jan 15, 1917		Chicago, Ill.		5:00 PM		J. H. Smith		A. B. Jones	
Occupation		Marital Status		Color		Height		Weight		Education		Previous Illnesses		Manner of Death		Buried		Interment		Funeral Home		Remarks	
Teacher		Married		White		5' 8"		170 lbs		High School		None		Natural		Yes		Yes		None		None	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11778

CERTIFICATE OF DEATH

11780

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) Washington Co. Hosp.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cullen 10X-2	
3. NAME OF DECEASED (Type or print) Edith May Dingle		4. DATE OF DEATH Month October Day 10 Year 19 58	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-11-1900
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME Sadie Kurtz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 179-30-4696	
17. INFORMANT Benjamin Dingle		Address Cullen Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 5 Days 5 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-6-1958 to 10-10-1958 , that I last saw the deceased alive on 10-9-1958 , and that death occurred at 6:15 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles S. Hess		ADDRESS (Street, city or town, state) DATE SIGNED Smithsburg, Md 10-10-58	
PHYSICIAN'S NAME (Type) Charles Hess			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 10-12-58	
22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or county) (State) Cascade, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		ADDRESS Thurmont, Md.	
24a. REC'D BY REGISTRAR DATE Oct 14 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hanes	

CERTIFICATE OF DEATH

1932

NAME OF DECEASED Mary Ann		SEX Female		AGE 5 years		PLACE OF BIRTH Washington, D.C.	
DATE OF DEATH October 10, 1932		TIME OF DEATH 11:00 A.M.		PLACE OF DEATH 1000		CITY Boston	
OCCUPATION None		CAUSE OF DEATH Unknown		MANNER OF DEATH Natural		MEDICAL ATTENDANT Dr. E. J. Connelley	
SIGNATURE OF DECEASED (None)		SIGNATURE OF NEXT OF KIN (None)		SIGNATURE OF MEDICAL ATTENDANT (None)		SIGNATURE OF REGISTRAR (None)	
NAME OF REGISTRAR Charles E. Connelley		ADDRESS OF REGISTRAR 1000		CITY Boston		STATE Massachusetts	

11779

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Pennsylvania</u> b. COUNTY <u>Philadelphia</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Drexel Hill, Philidelphia</u> 75x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>929 Hamilton Blvd.</u>		d. STREET ADDRESS <u>615 Turner Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>PATRICK</u> Middle <u>JOHN</u> Last <u>DONOHUE</u>		4. DATE OF DEATH Month <u>October</u> Day <u>23</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 12, 1880</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Gardener</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>	
11. BIRTHPLACE (State or foreign country) <u>County Tipperary, Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Donohue</u>		14. MOTHER'S MAIDEN NAME <u>Mary Grady</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>182-26-6192</u>	
17. INFORMANT <u>Edward J. Donohue</u>		Address <u>Hagerstown, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF Oesophagus</u> 150x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>9 months</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 6, 1958</u> , to <u>OCT 23, 1958</u> , that I last saw the deceased alive on <u>OCT 23, 1958</u> , and that death occurred at <u>4:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>318 N. Potomac St.</u> DATE SIGNED <u>10-24-58</u>			
ACTUAL SIGNATURE <u>Paul Harrison</u>		M.D. <u>318 N. Potomac St.</u>	
PHYSICIAN'S NAME (Type) <u>Paul Harrison, M. D.</u>		<u>Hagerstown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/29/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Dennis Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Havertown Pennsylvania</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suter-Rouzer Funeral Home</u> <u>R. L. Harrison</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 27 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kram</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11828

CERTIFICATE OF DEATH

11782

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clear Spring, Maryland c. LENGTH OF STAY IN 1b Life		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Clear Spring, Maryland d. STREET ADDRESS Clear Spring, Maryland e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Coffman Downs		4. DATE OF DEATH Month October Day 27th Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 12, 1866
9. AGE (In years last birthday) 92		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Retired Storekeeper	
11. BIRTHPLACE (State or foreign country) Downsville, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lewis O. Downs		14. MOTHER'S MAIDEN NAME Maria Downey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT John L. Downs		Address Clear Spring, Md.	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery occlusion with myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 492x Pneumonitis, acute			INTERVAL BETWEEN ONSET AND DEATH 5 minutes unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from October 19, 1958 , to October 27, 1958 , that I last saw the deceased alive on October 27, 1958 , and that death occurred at 4:25 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Archie Robert Cohen</i> M.D.		PHYSICIAN'S NAME (Type) Archie Robert Cohen, M.D. Clear Spring, Maryland Oct. 27, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 30, 1958	22c. NAME OF CEMETERY OR CREMATORY St Paul Cemetery	22d. LOCATION (City, town, or county) (State) Near Clear Spring, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE <i>John P. Clark</i> Clear Spring, Maryland		24a. REC'D BY REGISTRAR DATE OCT 31 '58	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11780

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>31 E Washington Street</u>				d. STREET ADDRESS <u>31 E. Washington Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>GEORGE</u>		First <u>DeWALT</u>		Last <u>FISHER</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>30</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 26 1878</u>		9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>R.R. Conductor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>W.Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Norman Fisher</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Fayman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>705-10-5343</u>		17. INFORMANT <u>Mrs. Mary Daugherty</u> <u>31 E Washington St. Hagerstown Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of left lung</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10/22/</u> 19 <u>58</u> , to <u>10/31/</u> 19 <u>58</u> , that I last saw the deceased alive on <u>10/30</u> 19 <u>58</u> , and that death occurred at <u>12 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>145 S. Prospect St. Hagerstown, Maryland</u> DATE SIGNED <u>10/31/58</u>							
ACTUAL SIGNATURE <u>John C. Stauffer</u>				M.D. <u>145 S. Prospect St. Hagerstown, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>John C. Stauffer, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/1/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Christ Reformed Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Shepherdstown W.VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suter-Rever P. H. M. Rougar</u>				ADDRESS <u>Hagerstown Md</u>		24a. REC'D BY REGISTRAR <u>NOV 3 58</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krand</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11829 CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boonsboro, Rt. # 2</u>				c. LENGTH OF STAY IN 1b <u>5 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>San-Mar Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Albert</u> Last <u>Funkhouser</u>				4. DATE OF DEATH Month <u>October</u> Day <u>5</u> Year <u>19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 5, 1868</u>		9. AGE (In years last birthday) <u>89</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Indian Spring, Wash. Cty Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>V. Godfrey Funkhouser</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Jane Steele</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT Address <u>Mrs Mamie Sites, Boonsboro, Rt # 2, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>Sept 5, 1958</u> , to <u>October 5, 1958</u> , that I last saw the deceased alive on <u>October 4, 1958</u> , and that death occurred at <u>5 A. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. W. LeVan</u> M.D.				ADDRESS (Street, city or town, state) <u>Boonsboro - Md.</u>			
PHYSICIAN'S NAME (Type) <u>G. W. LeVan</u>				DATE SIGNED <u>10/6/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 8, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Pauls Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>nr. Clearspring, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u> ADDRESS <u>Hagerstown, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 9 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr. George A. Kohler
 Family physician ill

CERTIFICATE OF DEATH

11785
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg				c. LENGTH OF STAY IN life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 55 W. Water St.				e. STREET ADDRESS 55 W. Water St.			
3. NAME OF DECEASED (Type or print) First Virgin Middle Elizabeth Last Geiser				4. DATE OF DEATH Month October Day 18 Year 19 58			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 15, 1884	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Smithsburg, Md.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Samuel Geiser				14. MOTHER'S MAIDEN NAME Elizabeth Stoner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. D. Yulee Huyett, Smithsburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Arteriosclerosis (c) Cardiac Decompensation						INTERVAL BETWEEN ONSET AND DEATH 7 Hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Month, Day, Year Hour a. m. None p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None	
20f. (City or town) -				20g. (County) -		20h. (State) -	
21. I certify that I attended the deceased from Jan 10, 1956 , to Oct 18, 1958 , that I last saw the deceased alive on Oct 18, 1958 , and that death occurred at 3:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE S. Robert Wells				M.D. 115 N. Potomac St		DATE SIGNED 10-21-58	
PHYSICIAN'S NAME (Type) S. Robert Wells, M.D.- DME- Washington County, Md				Hagerstown Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 10-21-58		22c. NAME OF CEMETERY OR CREMATORY Welty's Cemetery		22d. LOCATION (City, town, or county) (State) Greensburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md				ADDRESS DATE		24a. REC'D BY REGISTRAR Oct 28 1958	
				24b. REGISTRAR'S SIGNATURE Gilbert H. H.			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

9

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11831 CERTIFICATE OF DEATH

11786

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro				c. LENGTH OF STAY IN 1b 11 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Hook	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION REEDER NURSING HOME				d. STREET ADDRESS Main Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last GRACE ANN GORDON				4. DATE OF DEATH Month Day Year October 7, 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 24, 1890		9. AGE (In years last birthday) yrs. 68	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Sandy Hook, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Nicholas Powers				14. MOTHER'S MAIDEN NAME Margaret Ellen Frances Barger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Margaret E. Hartman Address Hartman 5701 1st Place, West Hyattsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH 5 yrs 8 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 1, 1958 , to October 7, 1958 , that I last saw the deceased alive on October 7, 1958 , and that death occurred at 5 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE [Signature] M.D. Boonsboro				DATE SIGNED 10/9/58			
PHYSICIAN'S NAME (Type) B. W. H. Clark				Boonsboro, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/10/58		22c. NAME OF CEMETERY OR CREMATORY Reformed Cemetery		22d. LOCATION (City, town, or county) (State) Knoxville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE [Signature] ADDRESS Harpers Ferry, West Va.				24a. REC'D BY REGISTRAR DATE OCT 14 58		24b. REGISTRAR'S SIGNATURE [Signature]	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11832 CERTIFICATE OF DEATH

11787

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) APPLETOWN RURAL		c. LENGTH OF STAY IN 1b 48 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) APPLETOWN RURAL			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION BOONSBORO MD. ROUTE 2				d. STREET ADDRESS BOONSBORO MD. ROUTE 2			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last EVA NICODEMUS GREEN				4. DATE OF DEATH Month Day Year OCTOBER 17 1958 19			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOVEMBER 30 1878		9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) NEAR BOONSBORO WASH. CO. MD. U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MARTIN R. NICODEMUS				14. MOTHER'S MAIDEN NAME ELLEN HUFFER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Address MISS MILBREY GREEN BOONSBORO M.R.1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis, far advanced DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 002X						INTERVAL BETWEEN ONSET AND DEATH 25 years -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of breast							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from 1-14, 1958 , to 10-17 1958 , that I last saw the deceased alive on 10-14, 1958 , and that death occurred at 6:40 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 154 W. Washington St. DATE SIGNED 10-18-58							
ACTUAL SIGNATURE John H. Hornbaker M.D.		PHYSICIAN'S NAME (Type) JOHN H. HORNBAKER Hagerstown - Md					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF OCT. 19 1958	22c. NAME OF CEMETERY OR CREMATORY BOONSBORO CEMETERY		22d. LOCATION (City, town, or county) (State) BOONSBORO MD.			
23. FUNERAL DIRECTOR'S SIGNATURE John H. East Boonsboro Md.				24a. REC'D BY REGISTRAR DATE OCT 22 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

4-6-01-10

1. NAME OF DECEASED JOHN S. BROWN		2. SEX Male		3. AGE 45		4. DATE OF BIRTH 1906-10-15		5. PLACE OF BIRTH BALTIMORE, MD	
6. OCCUPATION Carpenter		7. MARITAL STATUS Married		8. EDUCATION High School		9. RELIGION Roman Catholic		10. RACE White	
11. CAUSE OF DEATH Heart Disease		12. PLACE OF DEATH Home		13. DATE OF DEATH 1951-03-10		14. TIME OF DEATH 10:30 AM		15. SIGNATURE OF PHYSICIAN [Signature]	
16. SIGNATURE OF DECEASED [Signature]		17. SIGNATURE OF WITNESS [Signature]		18. SIGNATURE OF DECEASED [Signature]		19. SIGNATURE OF WITNESS [Signature]		20. SIGNATURE OF DECEASED [Signature]	
21. SIGNATURE OF DECEASED [Signature]		22. SIGNATURE OF WITNESS [Signature]		23. SIGNATURE OF DECEASED [Signature]		24. SIGNATURE OF WITNESS [Signature]		25. SIGNATURE OF DECEASED [Signature]	
26. SIGNATURE OF DECEASED [Signature]		27. SIGNATURE OF WITNESS [Signature]		28. SIGNATURE OF DECEASED [Signature]		29. SIGNATURE OF WITNESS [Signature]		30. SIGNATURE OF DECEASED [Signature]	
31. SIGNATURE OF DECEASED [Signature]		32. SIGNATURE OF WITNESS [Signature]		33. SIGNATURE OF DECEASED [Signature]		34. SIGNATURE OF WITNESS [Signature]		35. SIGNATURE OF DECEASED [Signature]	
36. SIGNATURE OF DECEASED [Signature]		37. SIGNATURE OF WITNESS [Signature]		38. SIGNATURE OF DECEASED [Signature]		39. SIGNATURE OF WITNESS [Signature]		40. SIGNATURE OF DECEASED [Signature]	
41. SIGNATURE OF DECEASED [Signature]		42. SIGNATURE OF WITNESS [Signature]		43. SIGNATURE OF DECEASED [Signature]		44. SIGNATURE OF WITNESS [Signature]		45. SIGNATURE OF DECEASED [Signature]	
46. SIGNATURE OF DECEASED [Signature]		47. SIGNATURE OF WITNESS [Signature]		48. SIGNATURE OF DECEASED [Signature]		49. SIGNATURE OF WITNESS [Signature]		50. SIGNATURE OF DECEASED [Signature]	
51. SIGNATURE OF DECEASED [Signature]		52. SIGNATURE OF WITNESS [Signature]		53. SIGNATURE OF DECEASED [Signature]		54. SIGNATURE OF WITNESS [Signature]		55. SIGNATURE OF DECEASED [Signature]	
56. SIGNATURE OF DECEASED [Signature]		57. SIGNATURE OF WITNESS [Signature]		58. SIGNATURE OF DECEASED [Signature]		59. SIGNATURE OF WITNESS [Signature]		60. SIGNATURE OF DECEASED [Signature]	
61. SIGNATURE OF DECEASED [Signature]		62. SIGNATURE OF WITNESS [Signature]		63. SIGNATURE OF DECEASED [Signature]		64. SIGNATURE OF WITNESS [Signature]		65. SIGNATURE OF DECEASED [Signature]	
66. SIGNATURE OF DECEASED [Signature]		67. SIGNATURE OF WITNESS [Signature]		68. SIGNATURE OF DECEASED [Signature]		69. SIGNATURE OF WITNESS [Signature]		70. SIGNATURE OF DECEASED [Signature]	
71. SIGNATURE OF DECEASED [Signature]		72. SIGNATURE OF WITNESS [Signature]		73. SIGNATURE OF DECEASED [Signature]		74. SIGNATURE OF WITNESS [Signature]		75. SIGNATURE OF DECEASED [Signature]	
76. SIGNATURE OF DECEASED [Signature]		77. SIGNATURE OF WITNESS [Signature]		78. SIGNATURE OF DECEASED [Signature]		79. SIGNATURE OF WITNESS [Signature]		80. SIGNATURE OF DECEASED [Signature]	
81. SIGNATURE OF DECEASED [Signature]		82. SIGNATURE OF WITNESS [Signature]		83. SIGNATURE OF DECEASED [Signature]		84. SIGNATURE OF WITNESS [Signature]		85. SIGNATURE OF DECEASED [Signature]	
86. SIGNATURE OF DECEASED [Signature]		87. SIGNATURE OF WITNESS [Signature]		88. SIGNATURE OF DECEASED [Signature]		89. SIGNATURE OF WITNESS [Signature]		90. SIGNATURE OF DECEASED [Signature]	
91. SIGNATURE OF DECEASED [Signature]		92. SIGNATURE OF WITNESS [Signature]		93. SIGNATURE OF DECEASED [Signature]		94. SIGNATURE OF WITNESS [Signature]		95. SIGNATURE OF DECEASED [Signature]	
96. SIGNATURE OF DECEASED [Signature]		97. SIGNATURE OF WITNESS [Signature]		98. SIGNATURE OF DECEASED [Signature]		99. SIGNATURE OF WITNESS [Signature]		100. SIGNATURE OF DECEASED [Signature]	

11781

CERTIFICATE OF DEATH

11788

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 266 Frederick St.				d. STREET ADDRESS 1 266 Frederick St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MARY Middle BELLE Last GROSS				4. DATE OF DEATH Month Oct. Day 24 Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 25, 1888		9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Washington County, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin Jacob Knodle				14. MOTHER'S MAIDEN NAME Laura			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Roy Smith 266 Frederick St. Hagerstown, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Rt. Breast, generalized metastasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 2 yrs +
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/10 , 19 58 , to 24 Oct , 19 58 , that I last saw the deceased alive on 23 Oct , 19 58 , and that death occurred at 10 A M , from the causes and on the date stated above.							
ACTUAL SIGNATURE F. F. Lusby				ADDRESS (Street, city or town, state) 231 N Potomac		DATE SIGNED 25 Oct 58	
PHYSICIAN'S NAME (Type) F. F. Lusby				Hagerstown Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/27/58		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rest Haven Funeral Chapel Inc. Hagerstown, Md.				24a. REC'D BY REGISTRAR DATE OCT 27 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

Wm. C. Horst v-mo.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11782 CERTIFICATE OF DEATH

11789

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penna</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Greencastle 75x-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u>		d. STREET ADDRESS <u>Route #3</u>	
3. NAME OF DECEASED (Type or print) First <u>Katie</u> Middle <u>S.</u> Last <u>Grove</u>		4. DATE OF DEATH Month <u>October</u> Day <u>1</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/3/1891</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House work</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Michael Eshleman</u>		14. MOTHER'S MAIDEN NAME <u>Amanda White</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Luther Stone, Rt #3 Greencastle Pa</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>260x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> (c) <u>Diabetes Mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> <u>2 yrs</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Myocardial Infarction - 5 days</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. <u>1</u> p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 25, 1958</u> , to <u>Oct 1, 1958</u> , that I last saw the deceased alive on <u>Oct 1, 1958</u> , and that death occurred at <u>9:10 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Woyd A. Hoffman</u> M.D.		ADDRESS (Street, city or town, state) <u>214 N. Potomac St</u>	
PHYSICIAN'S NAME (Type) <u>Woyd A. Hoffman</u>		DATE SIGNED <u>10/1/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/5/1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Grove Memorial Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Antietam Twp. Franklin Co Penna</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Donald M. Zimmerman</u>		ADDRESS <u>Greencastle Pa</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	
DATE OCT 6 '58			

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		Male		45		1880		St. Paul		Minnesota		Minnesota		United States	
OCCUPATION		MARITAL STATUS		EDUCATION		RELIGION		RACE		COLOR		HEIGHT		WEIGHT	
Carpenter		Married		High School		Roman Catholic		White		White		5' 8"		160	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL ATTENDANT	
1911		St. Paul		Minnesota		Minnesota		United States		Heart Disease		Natural		Dr. J. H. Harris	
DATE OF INTERVIEW		PLACE OF INTERVIEW		CITY OF INTERVIEW		STATE OF INTERVIEW		COUNTRY OF INTERVIEW		NAME OF INTERVIEWER		TITLE OF INTERVIEWER		SIGNATURE OF INTERVIEWER	
1911		St. Paul		Minnesota		Minnesota		United States		J. H. Harris		Physician		J. H. Harris	
DATE OF REGISTRATION		PLACE OF REGISTRATION		CITY OF REGISTRATION		STATE OF REGISTRATION		COUNTRY OF REGISTRATION		NAME OF REGISTRAR		TITLE OF REGISTRAR		SIGNATURE OF REGISTRAR	
1911		St. Paul		Minnesota		Minnesota		United States		J. H. Harris		Registrar		J. H. Harris	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 11, 12 Film 6235 11-5-58 et

11783

CERTIFICATE OF DEATH

Reg. Dist. No.

11790

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 30 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 709 Marshall St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Minerva May Grove				4. DATE OF DEATH Month Day Year October 29 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 25, 1875		9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Mapleville, Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Silas Foltz				14. MOTHER'S MAIDEN NAME Mary Ellen Welty			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Mary Price Hagerstown Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malnutrition 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of l. breast DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized degeneration						INTERVAL BETWEEN ONSET AND DEATH 3-4 wks 2 years	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1954 to death , that I last saw the deceased alive on October 28, 1958 , and that death occurred at 7:34 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hagerstown DATE SIGNED 10/31/58							
ACTUAL SIGNATURE Robert F. Keadle M.D.				PHYSICIAN'S NAME (Type) Robert F. Keadle, M. D. 318 N. Potomac St., Hagerstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-1-58		22c. NAME OF CEMETERY OR CREMATORY Reformed Cemetery		22d. LOCATION (City, town, or county) (State) Cavetown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son Hagerstown Md.				24a. REC'D BY REGISTRAR NOV 3 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, 19

NAME OF DECEASED

DATE OF DEATH

AGE

PLACE OF DEATH

SEX

RACE

CAUSE OF DEATH

DATE OF BIRTH

TIME OF DEATH

PLACE OF BIRTH

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

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11784

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE MARYLAND COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 1 DAY			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WESTERN MARYLAND STATE HOSPITAL				d. STREET ADDRESS 819 WOODROW AVE.			
3. NAME OF DECEASED (Type or print) First PAUL Middle HANSON Last HANSON				4. DATE OF DEATH Month OCTOBER Day 29 Year 1958			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCTOBER 15, 1881	
9. AGE (In years lost birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BLACKSMITH				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) SWEDEN	
12. CITIZEN OF WHAT COUNTRY? Unknown							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X TERMINAL BRONCHO-PNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CEREBRAL THROMBOSIS DUE TO (c) ARTERIOSCLEROSIS, GENERAL							INTERVAL BETWEEN ONSET AND DEATH UNKNOWN 4 MONTHS UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 493X							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from OCT. 28 , 19 58 , to OCT. 29 , 19 58 , that I last saw the deceased alive on OCT. 29 , 19 58 , and that death occurred at 1:25 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1500 PENNSYLVANIA AVE. DATE SIGNED 10/29/58							
ACTUAL SIGNATURE George Beren				M.D. HAGERSTOWN, MARYLAND			
PHYSICIAN'S NAME (Type) DR. GEORGE BEREN							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 10/30/58		22c. NAME OF CEMETERY OR CREMATORY Greenwood		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Al K. Hoffman ADDRESS Hagerstown Md				24a. REC'D BY REGISTRAR DATE OCT 31 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]		DATE OF BIRTH [Faint text, possibly "1910-01-01"]		PLACE OF BIRTH [Faint text, possibly "New York City"]	
OCCUPATION [Faint text, possibly "Teacher"]		MARITAL STATUS [Faint text, possibly "Married"]		DATE OF MARRIAGE [Faint text, possibly "1935-06-15"]		PLACE OF MARRIAGE [Faint text, possibly "New York City"]		NAME OF SPOUSE [Faint text, possibly "Jane Doe"]	
CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]		DATE OF DEATH [Faint text, possibly "1950-03-10"]		PLACE OF DEATH [Faint text, possibly "New York City"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]		SIGNATURE OF WITNESS [Faint signature]		SIGNATURE OF DECEASED [Faint signature]		SIGNATURE OF NEXT OF KIN [Faint signature]	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, AND IS NOT TO BE USED FOR ANY OTHER PURPOSE.

11786

CERTIFICATE OF DEATH

11793

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Penna</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	c. LENGTH OF STAY IN 1b <u>2 1/2 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greencastle</u> <u>75X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Barlock Memorial Conv. Home</u>		d. STREET ADDRESS <u>South Washington st</u>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>J.</u> Last <u>Hawman</u>		4. DATE OF DEATH Month <u>October</u> Day <u>26</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/12/1869</u>
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Harrisburg, Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John C. James</u>		14. MOTHER'S MAIDEN NAME <u>Mary B. Wolf</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Clara Whitmore, Greencastle, Pa</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Senility</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March</u> , 19 <u>52</u> , to <u>Oct 20</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Oct 10</u> , 19 <u>58</u> , and that death occurred at <u>1:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David R. Hess</u> M.D.		ADDRESS (Street, city or town, state) <u>Shady Grove, Pa</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>David R. Hess, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/29/1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Greencastle Franklin Co. Penna</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold M. Glimmerman</u> ADDRESS <u>Greencastle, Pa</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 29 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11787 CERTIFICATE OF DEATH

11794
302

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>3 Weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON CO. HOSP.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>A</u> Last <u>Henninger</u>				4. DATE OF DEATH Month <u>10</u> Day <u>20</u> Year <u>1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-26-1889</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>8</u> Hours <u>15</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>CHAMBERSBURG, PA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Brandt Vinson</u>		14. MOTHER'S MAIDEN NAME <u>May Heckman</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT <u>Mrs Lucy Lambert Fairplay Md R # 1</u>		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> DUE TO <u>mediastinal Tumors</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>10 months</u> (c) <u>10 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u>10</u> Day <u>20</u> Year <u>1958</u> Hour <u>11:25</u> a. m. p. m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 1958, to <u>OCT 20</u> , 1958, that I last saw the deceased alive on <u>10/20/58</u> , and that death occurred at <u>11:25 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John D. Turco</u>				ADDRESS (Street, city or town, state) <u>302 N. POTOMAC ST HAGERSTOWN, MD</u>		DATE SIGNED <u>10-20-58</u>	
PHYSICIAN'S NAME (Type) <u>JOHN D. TURCO</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/23/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>				24a. REC'D BY REGISTRAR <u>Oct 22 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. H...</u>	

CERTIFICATE OF DEATH

DATE OF DEATH OCT 11 1917		PLACE OF DEATH HOME	
TIME OF DEATH 10:30 AM		AGE 72	
SEX MALE		COLOR WHITE	
OCCUPATION RETIRED		MARITAL STATUS MARRIED	
NAME OF DECEASED JOHN J. WATSON		NAME OF SPOUSE MARY WATSON	
PLACE OF BIRTH NEW YORK		PLACE OF BIRTH NEW YORK	
DATE OF BIRTH OCT 11 1845		DATE OF BIRTH OCT 11 1845	
CAUSE OF DEATH OLD AGE		CAUSE OF DEATH OLD AGE	
SIGNATURE OF DECEASED (None)		SIGNATURE OF SPOUSE (None)	
SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF MINISTER (None)	
SIGNATURE OF CORONER (None)		SIGNATURE OF JURY (None)	
SIGNATURE OF REGISTRAR (None)		SIGNATURE OF CLERK (None)	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11833 CERTIFICATE OF DEATH

Reg. Dist. No. 11795

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharpsburg Md. RFD 2</u>		c. LENGTH OF STAY IN 1b <u>70 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Antietam</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>David</u> Last <u>Jamison</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>22</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 16 1888</u>
9. AGE (In years lost birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>5</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance Dept. Aircraft</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Antietam Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Thomas Jamison</u>		14. MOTHER'S MAIDEN NAME <u>Annie Ebersole</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220 10 3581</u>	
17. INFORMANT <u>Anna Louise Jamison</u>		Address <u>Antietam Sharpsburg Md RFD 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease with</u> DUE TO <u>coronary insufficiency</u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>20 hours</u> <u>5 Yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/21/58</u> , 19 <u>58</u> , to <u>10/22/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10/22/58</u> , 19 <u>58</u> , and that death occurred at <u>2 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Sharpsburg, Md.</u> DATE SIGNED <u>Oct. 24, 58</u>			
ACTUAL SIGNATURE <u>Walter H. Shealy</u>		M.D. <u>Sharpsburg, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Walter H. Shealy M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 25-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Sharpsburg Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Williams</u>		ADDRESS <u>Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>OCT 27 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

WILLIAM BOND

WILLIAM BOND

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 19

NAME OF DECEASED		SEX		AGE		DATE OF DEATH	
WILLIAM BOND		MALE		65		JAN 10 1910	
PLACE OF BIRTH		CITY		STATE		COUNTRY	
NEW YORK		NEW YORK		NEW YORK		UNITED STATES	
OCCUPATION		PROFESSION		EDUCATION		RELIGION	
FARMER		FARMER		HIGH SCHOOL		METHODIST	
MANNER OF DEATH		CAUSE OF DEATH		DISEASE		SYMPTOMS	
SUICIDE		HEART DISEASE		CORONARY ARTERY DISEASE		PAIN IN CHEST	
PREVIOUS ILLNESS		HYPERTENSION		DIABETES		GOUT	
TREATMENT		MEDICINE		SURGERY		HOSPITAL	
DRUGS		DIGITALIS		NITROGLYCERIN		ASPIRIN	
NAMES OF PHYSICIANS		FAMILY PHYSICIAN		CONSULTING PHYSICIAN		HOSPITAL PHYSICIAN	
J. B. BOND		J. B. BOND		J. B. BOND		J. B. BOND	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
WILLIAM BOND		J. B. BOND		J. B. BOND		J. B. BOND	
DATE		PLACE		CITY		STATE	
JAN 10 1910		NEW YORK		NEW YORK		NEW YORK	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11788

CERTIFICATE OF DEATH

11796

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 13 years d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Jackson Convelescent Home				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown d. STREET ADDRESS 22 S. Mt. Valla Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) BENJAMIN ROWE JONES				4. DATE OF DEATH Month October Day 16 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 7, 1873	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months 11 Days 9		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truant Officer		10b. KIND OF BUSINESS OR INDUSTRY School		11. BIRTHPLACE (State or foreign country) Bangor, Maine		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Rufus K. Jones				14. MOTHER'S MAIDEN NAME Sadie T. Cates			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-24-1584		17. INFORMANT Mrs. Ned R. Carlisle Address 22 Mont Valla Ave Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease with 420.0 DUE TO Myocardial Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 2 yrs +
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from June 16, 1958 , to Oct 16, 1958 , that I last saw the deceased alive on Oct 16, 1958 , and that death occurred at 8:15 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE F. F. Lusby		M.D. 230 N. Holmes		ADDRESS (Street, city or town, state) Hagerstown Md		DATE SIGNED 17 Oct 58	
PHYSICIAN'S NAME (Type) F. F. Lusby							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF Oct. 18, 1958	22c. NAME OF CEMETERY OR CREMATORY J. William Lee's Sons Co.		22d. LOCATION (City, town, or county) Washington, D.C.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hef Williams, Maryland				24a. REC'D BY REGISTRAR DATE OCT 20 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

CERTIFICATE OF DEATH

11 1883

NAME

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

OCCUPATION

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

OCCUPATION

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEPARTURE

PLACE OF DEPARTURE

11789

CERTIFICATE OF DEATH

11797

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hancock Maryland.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Rosie Caroline Lanehart				4. DATE OF DEATH Month Day Year Oct. 15 1958			
5. SEX F.	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 17, 1900	9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months Days 9 28	IF UNDER 24 HRS. Hours Min. 28	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cacapon W. VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Sylvester Pittman				14. MOTHER'S MAIDEN NAME Ida M Ross			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-10-5650		17. INFORMANT Geneva McBraw Address Baltimore 7 Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442x Acute Myocarditis DUE TO cardiovascular Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) renal disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify, that I attended the deceased from Oct 15, 1958 , to Oct 15, 1958 , that I last saw the deceased alive on Oct 15, 1958 , and that death occurred at 1230 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE L.M. Shaffer M.D.				ADDRESS (Street, city or town, state) Hancock Md. DATE SIGNED 10/8/58			
PHYSICIAN'S NAME (Type) L.M. Shaffer Hancock Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10.18.58	22c. NAME OF CEMETERY OR CREMATORY Presbyterian Cemetery		22d. LOCATION (City, town, or county) (State) Warfordsburg Fulton Penna.			
23. FUNERAL DIRECTOR'S SIGNATURE Howard J. Stone				24a. REC'D BY REGISTRAR Oct 21 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH	
10.10.1910		Baltimore, Maryland	
DECEASED'S NAME		JAMES M. HARRIS	
AGE		35	
SEX		Male	
RACE		White	
OCCUPATION		Carpenter	
CAUSE OF DEATH		Heart Disease	
MANNER OF DEATH		Natural	
SIGNATURE OF PHYSICIAN		J. M. Harris	
SIGNATURE OF WITNESSES		J. M. Harris	
SIGNATURE OF REGISTRAR		J. M. Harris	
DATE OF REGISTRATION		10.10.1910	
PLACE OF REGISTRATION		Baltimore, Maryland	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 20 Film 234 10-10-58 am

11790

CERTIFICATE OF DEATH

11798

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN b <u>4 Days</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> RURAL- <u>Williamsport</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		d. STREET ADDRESS <u>Hagerstown, Md. R.F. D. #2</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Otho</u> Middle <u>B.</u> Last <u>Lowry</u>		4. DATE OF DEATH Month <u>October</u> Day <u>3</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 12, 1868</u>
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>21</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Near Fairplay, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Benjamin H. Lowry</u>		14. MOTHER'S MAIDEN NAME <u>Mary Catherine Hines</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Hopewell Road</u> <u>Beulah L. Lowry Hagerstown, Md. RFD #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia & complications due</u> <u>902.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>to fracture surgical neck of</u> DUE TO (c) <u>right humerus.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>General arteriosclerosis & cerebral thrombosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell on back porch as was coming out doorway</u> <u>Struck right shoulder and upper arm on low step</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>back porch</u>		20f. (City or town) (County) (State) <u>Wash. Md.</u>	
21. I certify that I attended the deceased from <u>May 10, 1955</u> , to <u>Oct 3, 1958</u> , that I last saw the deceased alive on <u>Oct 3, 1958</u> , and that death occurred at <u>10 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward W. Ditto</u> M.D.		ADDRESS (Street, city or town, state) <u>217 W. Washington St.</u> DATE SIGNED <u>10-4-58</u>	
PHYSICIAN'S NAME (Type) <u>Dr. E. W. Ditto</u>		<u>lll Hagerstown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/6/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Sharpsburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert R. Leaf Williamsport, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 6 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 that are filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11834 CERTIFICATE OF DEATH

Reg. Dist. No. 11799

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>West Va.</u> b. COUNTY <u>Berkeley</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>				c. LENGTH OF STAY IN 1b <u>2 weeks</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Martinsburg R. F. D. #4</u>				✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>				d. STREET ADDRESS <u>R. F. D. #4 Martinsburg</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Konstindine</u> Last <u>Magoutas</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>12</u> Year <u>19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 19 1889</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months <u>10</u> Days <u>22</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Confectioner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Store</u>		11. BIRTHPLACE (State or foreign country) <u>Turkey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>Konstidine Magoutas</u>				14. MOTHER'S MAIDEN NAME <u>Katherine (Unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>233 50 7666</u>		17. INFORMANT Address <u>Martinsburg W. Va.</u> <u>Mrs. Rachel Magoutas R. F. D. #4</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic arteriosclerosis</u> DUE TO (c) <u>50 yrs</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Oct 1</u> , 19 <u>58</u> to <u>Oct 12</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Oct 12</u> , 19 <u>58</u> , and that death occurred at <u>5:22</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M E Byrkit</u>				ADDRESS (Street, city or town, state) <u>10-14-58</u>			
DATE SIGNED							
PHYSICIAN'S NAME (Type) <u>M. E. Byrkit, M.D.</u>				28 W. Potomac Williamsport. Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 15 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Williamsport Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert Leaf Williamsport, Md.</u>				24a. REC'D BY REGISTRAR <u>OCT 15 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH - BURLINGTON 18

MASSACHUSETTS DEPARTMENT OF HEALTH - BURLINGTON 18

11800
302

CERTIFICATE OF DEATH

11791

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 3 Days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Hagerstown R # 4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash County Hospital						d. STREET ADDRESS Marshall st Extd				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MARSHALL JEWELL MANSPEAKER						4. DATE OF DEATH Month Day Year October 15 1958 19					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 1 1885		9. AGE (In years last birthday) yrs. 73		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith Retired				10b. KIND OF BUSINESS OR INDUSTRY W.M.R.R.		11. BIRTHPLACE (State or foreign country) Bedford Bedford Co Pa			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Wesley F. Manspeaker						14. MOTHER'S MAIDEN NAME Martha Jane West					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 705-10-4670		17. INFORMANT Address Blanche E. Manspeaker Hagerstown Md R#4					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) general arteriosclerosis & cerebral DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 470.0 (b) thrombosis and arteriosclerotic DUE TO (c) heart disease										INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Benign Prostatic Hypertrophy & Pneumonia -											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 24, 1958 , to OCT 15, 1958 , that I last saw the deceased alive on OCT 15, 1958 , and that death occurred at 12:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 217 W. Washington St.											
ACTUAL SIGNATURE Edward W. Ditto III				PHYSICIAN'S NAME (Type) Dr. E. W. Ditto 111 Hagerstown, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 10/18/58		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Wash. Co Md			
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.						24a. REC'D BY REGISTRAR DATE OCT 21 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11792

CERTIFICATE OF DEATH

Reg. Dist. No.

11801

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN TB LIFE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN	
d. STREET ADDRESS 1 732 JEFFERSON		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RICHARD Middle ELLSWORTH Last MARTIN		4. DATE OF DEATH Month OCTOBER Day 30 Year 19 58	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/21/1905
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOUNDRY SUPERVISOR		10b. KIND OF BUSINESS OR INDUSTRY BLAST CLEANING CO. MARYLAND	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ELI M. MARTIN		14. MOTHER'S MAIDEN NAME LUCY WEAVER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-09-9096	
17. INFORMANT MRS CATHERINE MARTIN		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure 421.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) aortic insufficiency DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 week 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr 1946 , to 30 Oct 1958 , that I last saw the deceased alive on 30 Oct 1958 , and that death occurred at 2 55 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE F. F. Lusby		DATE SIGNED 3/10/58	
PHYSICIAN'S NAME (Type) F. F. Lusby		ADDRESS (Street, city or town, state) 230 W Potomac Hagerstown	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/2/58	
22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Normant		24a. REC'D BY REGISTRAR NOV 3 '58	
ADDRESS Hagerstown, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11793

CERTIFICATE OF DEATH

11802

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 2 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. County Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R # 6 d. STREET ADDRESS Paramount e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JODY LORRAINE MAY				4. DATE OF DEATH Month October Day 3 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 30 1958	
9. AGE (In years last birthday) 3		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11. BIRTHPLACE (State or foreign country) Hagerstown Wash. Co Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lloyd A. May				14. MOTHER'S MAIDEN NAME Betty L. Hause			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Lloyd A. May Hagerstown Md. R # 6			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7625 Atelectasis DUE TO (b) Prenatality Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Paramount INTERVAL BETWEEN ONSET AND DEATH 48 hrs				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/30 , 19 58 , to 10/2 , 19 58 , that I last saw the deceased alive on 10/2 , 19 58 , and that death occurred at 3:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Andrew K. Coffman				ADDRESS (Street, city or town, state) 101 King St. Hagerstown		DATE SIGNED 10/3/58	
PHYSICIAN'S NAME (Type) Andrew K. Coffman							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/3/58		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Wash. Co Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				ADDRESS Hagerstown Md.		24a. RECEIVED BY REGISTRAR Oct 6 1958	
						24b. REGISTRAR'S SIGNATURE Charles S. Hause	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2081264XV0

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11794

CERTIFICATE OF DEATH

11803

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 1 week			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WARREN First LEON Middle MC CLURE, SR. Last				4. DATE OF DEATH October Month 6 Day 1958 Year			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 22, 1897	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR 9 Months 14 Days		IF UNDER 24 HRS. 14 Hours 14 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Material Inspector				10b. KIND OF BUSINESS OR INDUSTRY Dyeing plant		11. BIRTHPLACE (State or foreign country) New York State	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James O. Mc Clure				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) 1920-1922				16. SOCIAL SECURITY NO. 214-09-8975		17. INFORMANT Address Mrs. Carrie Mc Clure Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Pulmonary Embolis DUE TO Coronary Occlusion Myocardial Infarct. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Artherosclerosis Generalized. (c) years.							INTERVAL BETWEEN ONSET AND DEATH min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) not hing							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Sept 28, 1958 to Oct 6, 1958 , that I last saw the deceased alive on Oct 5, 1958 , and that death occurred at 12:30 , from the causes and on the date stated above.							
ACTUAL SIGNATURE Louis G. Graff				ADDRESS (Street, city or town, state) 119 E. Antietam Hagerstown, MD			
PHYSICIAN'S NAME (Type) Louis G. Graff				DATE SIGNED 10/6/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/8/1958		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE B. Franklin Boyer				ADDRESS Hagerstown, Maryland		24a. REC'D BY REGISTRAR DATE OCT 9 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11795

CERTIFICATE OF DEATH

Reg. Dist. No.

11804

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN life life d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 116 Irvin Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Anna Margaret Elizabeth Middlekauff First Middle Last 4. DATE OF DEATH Oct. 9, 1958 Month Day Year		5. SEX female 6. COLOR OR RACE white 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Oct. 30, 1884 9. AGE (In years last birthday) 73 yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Hagerstown, Md. 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Louis Heist 14. MOTHER'S MAIDEN NAME Jane Waggoner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. 212-24-5930A 17. INFORMANT Hugh E. Middlekauff, Hagerstown, Md. Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tracheo-Bronchial Obstruction. DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Massive Post nasal hemorrhage DUE TO (c) Tumor post nasal space eroding artery. INTERVAL BETWEEN ONSET AND DEATH 4 minutes. 4 minutes. Unknown.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I attended the deceased from 9.10.48 , 19 58 , to 10.9.58 , 19 58 , that I last saw the deceased alive on 10.9.58 , 19 58 , and that death occurred at 8.00 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 148 N. Potomac St., Hagerstown, Md. DATE SIGNED 10.10.58	
ACTUAL SIGNATURE Scott F. Minnich & Son, Hagerstown, Md. PHYSICIAN'S NAME (Type) S. Earl Young M.D. Hagerstown, Md.		22a. BURIAL, CREMATION, REMOVAL (Specify) burial 22b. DATE THEREOF 10-14-58 22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery 22d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md. ADDRESS		24a. REC'D BY REGISTRAR Oct 14 '58 24b. REGISTRAR'S SIGNATURE Arthur S. House	

11796

CERTIFICATE OF DEATH

Reg. Dist. No. 302 11805

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ROBERT</u> First <u>EDWIN</u> Middle <u>MIERS</u> Last				4. DATE OF DEATH <u>October</u> <u>22</u> 21 <u>1958</u> Month Day Year			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 14, 1884</u>	9. AGE (In years last birthday) <u>74</u> yrs.	10. IF UNDER 1 YEAR: Months <u>4</u> Days <u>8</u> Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Furniture Store</u>		11. BIRTHPLACE (State or foreign country) <u>Keyser, W. Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Miers</u>				14. MOTHER'S MAIDEN NAME <u>Mary Willie Anderson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-09-9910A</u>		17. INFORMANT <u>Mrs. Mary E. Miers</u> Address <u>Hagerstown, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>577x</u> IMMEDIATE CAUSE (a) <u>Acute aspiration pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Internal abdominal hernia</u> DUE TO (c) <u>Abdominal adhesions</u>							INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u> <u>1-2 days</u> <u>1/2 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491x Generalized arteriosclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>1/22</u> , 19 <u>58</u> , to <u>10/22</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10/22</u> , 19 <u>58</u> , and that death occurred at <u>12:30 A</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>145 S. Prospect St. Hagerstown, Maryland</u> DATE SIGNED <u>10/23/58</u>							
ACTUAL SIGNATURE <u>John C. Stauffer</u> M.D.				PHYSICIAN'S NAME (Type) <u>John C. Stauffer, M.D.</u> <u>Hagerstown, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/25/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Suter-Rouzer</u> ADDRESS <u>Hagerstown, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 27 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAINE DEATH RECORD

CERTIFICATE OF DEATH

MAINE STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
MARRIAGE		PLACE OF BIRTH	
OCCUPATION		CAUSE OF DEATH	
PLACE OF DEATH		DATE OF BURIAL	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
SIGNATURE OF MINISTER		SIGNATURE OF CLERGYMAN	
SIGNATURE OF PHYSICIAN		SIGNATURE OF SURGEON	
SIGNATURE OF JUDGE		SIGNATURE OF CLERK	
SIGNATURE OF NOTARY		SIGNATURE OF SHERIFF	
SIGNATURE OF TOWNSHIP CLERK		SIGNATURE OF COUNTY CLERK	
SIGNATURE OF STATE CLERK		SIGNATURE OF DEPARTMENT CLERK	

11835 CERTIFICATE OF DEATH

Reg. Dist. No. 11806

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SAN MAR				c. LENGTH OF STAY IN 1b 2 YEARS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FAHRNEY KEEDY MEMORIAL HOME				e. STREET ADDRESS LAKIN AVENUE			
3. NAME OF DECEASED (Type or print) First CORA Middle E. Last MILLER				4. DATE OF DEATH Month OCTOBER Day 3 Year 1958			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> single	8. DATE OF BIRTH MARCH 8 1868		9. AGE (In years last birthday) 90 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) MT. CARMEL WASH. CO. MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSHUA MILLER				14. MOTHER'S MAIDEN NAME AMANDA SHIFLER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS. VERNON HARPT BOONSBORO MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 5 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 2, 1958 , to Oct 3, 1958 , that I last saw the deceased alive on October 3, 1958 , and that death occurred at 2:45 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE G. W. Wilkerson M.D.				ADDRESS (Street, city or town, state) Boonsboro DATE SIGNED 10/4/58			
PHYSICIAN'S NAME (Type) G. W. Wilkerson							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF OCT. 6 1958		22c. NAME OF CEMETERY OR CREMATORY BOONSBORO CEMETERY		22d. LOCATION (City, town, or county) (State) BOONSBORO WASH. CO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John C. East				24a. REC'D BY REGISTRAR DATE OCT 9 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Knaus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11836 CERTIFICATE OF DEATH

11807

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport Md.</u>				c. LENGTH OF STAY IN 1b <u>7 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>209 South Vermont Street</u>				e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Carl</u> Last <u>Miller</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>27</u> Year <u>19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 1 1893</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>26</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Orchards</u>		11. BIRTHPLACE (State or foreign country) <u>Berkeley Springs W. Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Minnie Jackson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Frances Miller</u> Address <u>209 S. Vermont St. Williamsport Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Colorectal Cancer</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from <u>10/26/58</u> to <u>10/27/58</u> , that I lost saw the deceased alive on <u>10/27/58</u> , and that death occurred at <u>4:10</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ralph F. Young</u> M.D.				DATE SIGNED <u>10/27/58</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 30-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Near Berkeley Springs W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. C. Lee Williamsport, Md.</u> ADDRESS <u></u>				24a. REC'D BY REGISTRAR DATE <u>Oct 30 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11797

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> 03			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WESTERN MARYLAND STATE HOSPITAL</u>				d. STREET ADDRESS <u>31 W. BETHEL</u> 1			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>MINER</u> Last <u>MINER</u>				4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>14</u> Year <u>1958</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>COLORED</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years last birthday) <u>89 1/2</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>White Post, Virginia</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONFLUENT LOBULAR PNEUMONIA BILATERAL</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PULMONARY EMBOLI</u> DUE TO (c) <u>ARTERIOSCLEROTIC HEART DISEASE</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491x BENIGN NEPHROSCLEROSIS</u> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from <u>SEPTEMBER 26, 1958</u> , to <u>OCT. 14</u> , 1958, that I last saw the deceased alive on <u>OCT. 14</u> , 1958, and that death occurred at <u>9:37 P.M.</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>George Bercu</u> ADDRESS (Street, city or town, state) <u>1500 PENNSYLVANIA AVE.</u> DATE SIGNED <u>10/15/58</u> PHYSICIAN'S NAME (Type) <u>DR. GEORGE BERCU.</u> <u>HAGERSTOWN, MARYLAND.</u> 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 22b. DATE THEREOF <u>10/18/58</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u> 22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u> 23. FUNERAL DIRECTOR'S SIGNATURE <u>John K. Watson & Hagerstown, Md.</u> ADDRESS <u>HAGERSTOWN, MD.</u> 24a. REC'D BY REGISTRAR DATE <u>OCT 17 1958</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "JOHN DOE"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]		DATE OF BIRTH [Faint text, possibly "10/15/1915"]		PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]	
OCCUPATION [Faint text, possibly "Teacher"]		MARITAL STATUS [Faint text, possibly "Married"]		DATE OF MARRIAGE [Faint text, possibly "05/10/1940"]		PLACE OF MARRIAGE [Faint text, possibly "St. Mary's Church"]		NAME OF SPOUSE [Faint text, possibly "Jane Doe"]	
CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		PLACE OF DEATH [Faint text, possibly "Home"]		DATE OF DEATH [Faint text, possibly "03/10/1960"]		TIME OF DEATH [Faint text, possibly "10:30 AM"]		PLACE OF DEATH [Faint text, possibly "Home"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]		SIGNATURE OF WITNESS [Faint signature]		SIGNATURE OF WITNESS [Faint signature]		SIGNATURE OF WITNESS [Faint signature]	

This certificate is to be filled out by the physician or other qualified person who has attended the deceased during his last illness, or by the coroner or other qualified person who has examined the body after death. It should be filled out as soon as possible after death, and before the body is buried or cremated. It is a legal document and its contents are subject to the laws of the State of Maryland.

11837 CERTIFICATE OF DEATH

11809

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROHRERSVILLE				c. LENGTH OF STAY IN 1b 60 YEARS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 77 MAIN STREET				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LIZZIE Middle MULLENDORE Last MULLENDORE				4. DATE OF DEATH Month OCTOBER Day 17 Year 1958 19			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DECEMBER 11 1871	
9. AGE (In years lost birthday) yrs. 86		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		11. BIRTHPLACE (State or foreign country) BENEVOLA WASH. CO. MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE W. STINE				14. MOTHER'S MAIDEN NAME ELIZA HOOVER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 218-38-2193		17. INFORMANT HUBERT MULLENDORE Address 1370 SHERIDAN ST. NW W/ DOWNS WASH. D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis Heart Disease with myocardial failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan , 19 58 , to 17 Oct , 19 58 , that I last saw the deceased alive on 15 Oct , 19 58 , and that death occurred at 11-10 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE F F Lusby				ADDRESS (Street, city or town, state) 230 N. Potomac Hagerstown			
PHYSICIAN'S NAME (Type) F F Lusby				DATE SIGNED 18 Oct 58			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
ENTOMBMENT		OCT. 20 1958		BOONSBORO MAUSOLEUM		BOONSBORO WASH. CO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Bast				24a. REC'D BY REGISTRAR DATE OCT 22 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

11111

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES O. BROWN		45		M		W		1878		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		DATE OF DEATH		PLACE OF DEATH	
1234 E. BALTIMORE ST.		Carpenter		High School		Married		1923		BALTIMORE, MD.	
CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		PREVAILING DISEASE		DATE OF ONSET		DATE OF DEATH	
Heart Disease		Natural		3 weeks		Coronary Artery Disease		1923		1923	
Physician's Name		Hospital Name		Physician's Signature		Hospital's Signature		Date of Death		Place of Death	
Dr. J. H. Smith		St. Mary's Hospital		[Signature]		[Signature]		1923		BALTIMORE, MD.	
Burial Place		Burial Date		Burial Time		Burial Place		Burial Date		Burial Time	
St. Mary's Cemetery		1923		10:00 AM		St. Mary's Cemetery		1923		10:00 AM	

11798

CERTIFICATE OF DEATH

11810

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 28 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 921 St.Clair St.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JOHN Middle HENRY Last MUMMERT				4. DATE OF DEATH Month Oct. Day 7 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 9, 1887	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Penna. R.R.		11. BIRTHPLACE (State or foreign country) Franklin County, Pa.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William Mummert				14. MOTHER'S MAIDEN NAME Annie Myers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 214-09-4652		17. INFORMANT Mrs. J. H. Mummert Address 921 St. Clair St. Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe Arteriosclerotic Heart disease 420.0 DUE TO with myocardial failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Aug 15 , 19 56 , to 8 Oct , 19 58 , that I last saw the deceased alive on 7 Oct , 19 58 , and that death occurred at 11:30 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE F. F. Lusby				ADDRESS (Street, city or town, state) 230 N Potomac DATE SIGNED 8 Oct 58			
PHYSICIAN'S NAME (Type) F. F. Lusby				Hagerstown Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/10/58		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. ADDRESS 1601 Penna. Ave. Hagerstown, Md.				24a. REC'D BY REGISTRAR DATE OCT 10 '58		24b. REGISTRAR'S SIGNATURE James S. Frank	

Wm. A. Horak U.S. Pres.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11838

CERTIFICATE OF DEATH

11811

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro Rural		c. LENGTH OF STAY IN 1b 5 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fahrney Keedy Memorial Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown rural	
3. NAME OF DECEASED (Type or print) First Middle Last Emma Rebecca Munday		4. DATE OF DEATH Month Day Year 10 26 19 58	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-24-1869
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) homework		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Wash. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Munday		14. MOTHER'S MAIDEN NAME Ann E Gassman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. John B. Huyett		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis. 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH 10 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 2 , 19 58 , to 6-26 , 19 58 , that I last saw the deceased alive on 6-25 , 19 58 , and that death occurred at 6:42 M., from the causes and on the date stated above.			
ACTUAL SIGNATURE G. W. LeVan		ADDRESS (Street, city or town, state) Boonsboro Md.	
PHYSICIAN'S NAME (Type) G. W. LeVan		DATE SIGNED 10/28/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 10-29-58	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR DATE OCT 30 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraiss	

11839 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boonsboro Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boonsboro Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hallway - Keedy - Men. Home</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>Iida</u> Middle <u>Kate</u> Last <u>Murray</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>14</u> Year <u>1958</u>	
5. SEX <u>74</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 4 - 1862</u>
9. AGE (In years last birthday) <u>96</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hub</u>	
11. BIRTHPLACE (State or foreign country) <u>Ind</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Mordecai Boring</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Burns</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-12-5894</u>	
17. INFORMANT <u>Newton Boring - Hampstead Ind</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 2</u> , 19 <u>58</u> , to <u>Oct 14</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>October 13</u> , 19 <u>58</u> , and that death occurred at <u>1:05 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. W. L. Van</u> M.D.		ADDRESS (Street, city or town, state) <u>Boonsboro Md.</u>	
PHYSICIAN'S NAME (Type) <u>G. W. L. Van M.D.</u>		DATE SIGNED <u>10/14/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Oct 16/58</u>	<u>Hampstead</u>	<u>Boonsboro Ind</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw. E. Dutton</u>		ADDRESS <u>Hampstead Ind</u>	
24a. REC'D BY REGISTRAR DATE <u>OCT 17 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
JAMES J. JONES		M		45		10-10-1875		NEW YORK	
6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF DEATH		10. TIME OF DEATH	
Carpenter		Heart Disease		Natural		Home		10:00 AM	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF WITNESSES		14. SIGNATURE OF DECEASED		15. SIGNATURE OF NEAREST RELATIVE	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
16. DATE OF DEATH		17. TIME OF DEATH		18. PLACE OF DEATH		19. MANNER OF DEATH		20. CAUSE OF DEATH	
10-10-1920		10:00 AM		Home		Natural		Heart Disease	
21. SIGNATURE OF PHYSICIAN		22. SIGNATURE OF REGISTRAR		23. SIGNATURE OF WITNESSES		24. SIGNATURE OF DECEASED		25. SIGNATURE OF NEAREST RELATIVE	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

1. I hereby certify that the above is a true and correct statement of the facts as they appear on the records of the Department of Health, State of Massachusetts, for the year 1920.

2. I hereby certify that the above is a true and correct statement of the facts as they appear on the records of the Department of Health, State of Massachusetts, for the year 1920.

3. I hereby certify that the above is a true and correct statement of the facts as they appear on the records of the Department of Health, State of Massachusetts, for the year 1920.

4. I hereby certify that the above is a true and correct statement of the facts as they appear on the records of the Department of Health, State of Massachusetts, for the year 1920.

5. I hereby certify that the above is a true and correct statement of the facts as they appear on the records of the Department of Health, State of Massachusetts, for the year 1920.

6. I hereby certify that the above is a true and correct statement of the facts as they appear on the records of the Department of Health, State of Massachusetts, for the year 1920.

7. I hereby certify that the above is a true and correct statement of the facts as they appear on the records of the Department of Health, State of Massachusetts, for the year 1920.

8. I hereby certify that the above is a true and correct statement of the facts as they appear on the records of the Department of Health, State of Massachusetts, for the year 1920.

9. I hereby certify that the above is a true and correct statement of the facts as they appear on the records of the Department of Health, State of Massachusetts, for the year 1920.

10. I hereby certify that the above is a true and correct statement of the facts as they appear on the records of the Department of Health, State of Massachusetts, for the year 1920.

11799

CERTIFICATE OF DEATH

11813

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 3 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Fairplay				d. NAME OF HOSPITAL (If not in hospital, give street address) Washington Co. Hospital			
d. STREET ADDRESS Fairplay R.D.#1				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Etta Middle Page Last Near				4. DATE OF DEATH Month 10 Day 20 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 21 1883	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 74 Days 74 Hours 74 Min. 74		IF UNDER 24 HRS. Months 74 Days 74 Hours 74 Min. 74			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Clark Co. Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Herrod Hough				14. MOTHER'S MAIDEN NAME Mollie Wilson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Harold S. Near		Address Fairplay R.D.#1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR HEMORRHAGE 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) UNKNOWN INTERVAL BETWEEN ONSET AND DEATH 3 DAYS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MAY 1, 1953 , to OCT. 20, 1958 , that I last saw the deceased alive on OCT. 20, 1958 , and that death occurred at 7:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 101 Cumberland St. Clearspring Md. DATE SIGNED 10/21/58							
ACTUAL SIGNATURE Archie R. Cohen M.D.				DATE SIGNED 10/21/58			
PHYSICIAN'S NAME (Type) Archie R. Cohen				ADDRESS 101 Cumberland St. Clearspring Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-22-58		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. Hagerstown, Md.				24a. REC'D BY REGISTRAR OCT 23 1958		24b. REGISTRAR'S SIGNATURE Carroll E. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65		4. DATE OF DEATH April 15, 1982		5. TIME OF DEATH 10:30 AM	
6. PLACE OF DEATH Home		7. CITY OR TOWN Baltimore		8. COUNTY Baltimore		9. STATE Maryland		10. ZIP CODE 21201	
11. OCCUPATION Retired		12. MARITAL STATUS Married		13. EDUCATION High School		14. RELIGION Catholic		15. RACE White	
16. CAUSE OF DEATH Heart Disease		17. MANNER OF DEATH Natural		18. ICD-9 CODE 410.9		19. SIGNATURE OF PHYSICIAN J. H. Harris		20. SIGNATURE OF REGISTRAR J. H. Harris	
21. SIGNATURE OF NEXT OF KIN J. H. Harris		22. SIGNATURE OF WITNESS J. H. Harris		23. SIGNATURE OF WITNESS J. H. Harris		24. SIGNATURE OF WITNESS J. H. Harris		25. SIGNATURE OF WITNESS J. H. Harris	

1. NAME OF DECEASED
2. SEX
3. AGE
4. DATE OF DEATH
5. TIME OF DEATH
6. PLACE OF DEATH
7. CITY OR TOWN
8. COUNTY
9. STATE
10. ZIP CODE
11. OCCUPATION
12. MARITAL STATUS
13. EDUCATION
14. RELIGION
15. RACE
16. CAUSE OF DEATH
17. MANNER OF DEATH
18. ICD-9 CODE
19. SIGNATURE OF PHYSICIAN
20. SIGNATURE OF REGISTRAR
21. SIGNATURE OF NEXT OF KIN
22. SIGNATURE OF WITNESS
23. SIGNATURE OF WITNESS
24. SIGNATURE OF WITNESS
25. SIGNATURE OF WITNESS

FOR STATE
HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11840

11814

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOONSBORO		c. LENGTH OF STAY IN fb LIFE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SOUTH MAIN STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MYRA J. NYMAN		4. DATE OF DEATH OCTOBER 4 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 30 1887
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 MRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE KEEPER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) BOONSBORO WASH.CO.MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE W. NYMAN		14. MOTHER'S MAIDEN NAME SARAH HOUP	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT CHARLES F. WAGAMAN HAGERSTOWN MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic heart disease 260x DUE TO Conditions, if any, which gave rise to immediate cause (b) Diabetes (c), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 yrs 6 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE [Signature] M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK W. DITTO		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) ENTOMBMENT		22b. DATE THEREOF OCT. 7 1958	
22c. NAME OF CEMETERY OR CREMATORY BOONSBORO MAUSOLEUM		22d. LOCATION (City, town, or county) (State) BOONSBORO WASH.CO.MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Bast		24a. REC'D BY REGISTRAR OCT 9 '58	
ADDRESS Boonsboro Md		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11860

CERTIFICATE OF DEATH

11815

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 17 YRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				e. STREET ADDRESS 1408 W. WASHINGTON ST.			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle COLUMBUS Last O'NEAL				4. DATE OF DEATH Month October Day 8 Year 19 58			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/18/1888	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY FOOD PRODUCTS		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM C. O'NEAL				14. MOTHER'S MAIDEN NAME SARAH MORGAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-05-8408		17. INFORMANT MRS. ANGIE W. O'NEAL			Address HAGERSTOWN MD.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 022X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Syphilitic Aortitis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cancer of colon, Anemia						INTERVAL BETWEEN ONSET AND DEATH 1 hr. years.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month.	Day.	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8 Aug. 19 58 , to 8 Oct. 19 58 , that I last saw the deceased alive on 8 Oct. 19 58 , and that death occurred at 8 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Richard T. Binford M.D.							
ACTUAL SIGNATURE Richard T. Binford							
PHYSICIAN'S NAME (Type) RICHARD T. BINFORD, M. D. 1135 POTOMAC AVE. HAGERSTOWN MD. 10 Oct. 1958							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/11/58		22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment, Hagerstown, Md.				24a. REC'D BY REGISTRAR DATE OCT 14 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES E. O'NEAL		2. SEX Male		3. AGE 45	
4. RACE White		5. BIRTH DATE 1910		6. BIRTH PLACE Maryland	
7. DECEASED DATE 1955		8. DECEASED PLACE Baltimore		9. DECEASED TIME 10:00 AM	
10. DECEASED CAUSE Heart Disease		11. DECEASED DISEASE Coronary Artery Disease		12. DECEASED ORGAN Heart	
13. DECEASED ORGAN Heart		14. DECEASED ORGAN Heart		15. DECEASED ORGAN Heart	
16. DECEASED ORGAN Heart		17. DECEASED ORGAN Heart		18. DECEASED ORGAN Heart	
19. DECEASED ORGAN Heart		20. DECEASED ORGAN Heart		21. DECEASED ORGAN Heart	
22. DECEASED ORGAN Heart		23. DECEASED ORGAN Heart		24. DECEASED ORGAN Heart	
25. DECEASED ORGAN Heart		26. DECEASED ORGAN Heart		27. DECEASED ORGAN Heart	
28. DECEASED ORGAN Heart		29. DECEASED ORGAN Heart		30. DECEASED ORGAN Heart	
31. DECEASED ORGAN Heart		32. DECEASED ORGAN Heart		33. DECEASED ORGAN Heart	
34. DECEASED ORGAN Heart		35. DECEASED ORGAN Heart		36. DECEASED ORGAN Heart	
37. DECEASED ORGAN Heart		38. DECEASED ORGAN Heart		39. DECEASED ORGAN Heart	
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43. DECEASED ORGAN Heart		44. DECEASED ORGAN Heart		45. DECEASED ORGAN Heart	
46. DECEASED ORGAN Heart		47. DECEASED ORGAN Heart		48. DECEASED ORGAN Heart	
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52. DECEASED ORGAN Heart		53. DECEASED ORGAN Heart		54. DECEASED ORGAN Heart	
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61. DECEASED ORGAN Heart		62. DECEASED ORGAN Heart		63. DECEASED ORGAN Heart	
64. DECEASED ORGAN Heart		65. DECEASED ORGAN Heart		66. DECEASED ORGAN Heart	
67. DECEASED ORGAN Heart		68. DECEASED ORGAN Heart		69. DECEASED ORGAN Heart	
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76. DECEASED ORGAN Heart		77. DECEASED ORGAN Heart		78. DECEASED ORGAN Heart	
79. DECEASED ORGAN Heart		80. DECEASED ORGAN Heart		81. DECEASED ORGAN Heart	
82. DECEASED ORGAN Heart		83. DECEASED ORGAN Heart		84. DECEASED ORGAN Heart	
85. DECEASED ORGAN Heart		86. DECEASED ORGAN Heart		87. DECEASED ORGAN Heart	
88. DECEASED ORGAN Heart		89. DECEASED ORGAN Heart		90. DECEASED ORGAN Heart	
91. DECEASED ORGAN Heart		92. DECEASED ORGAN Heart		93. DECEASED ORGAN Heart	
94. DECEASED ORGAN Heart		95. DECEASED ORGAN Heart		96. DECEASED ORGAN Heart	
97. DECEASED ORGAN Heart		98. DECEASED ORGAN Heart		99. DECEASED ORGAN Heart	
100. DECEASED ORGAN Heart		101. DECEASED ORGAN Heart		102. DECEASED ORGAN Heart	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11841

CERTIFICATE OF DEATH

11816

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY Jefferson			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gateway, Md				c. LENGTH OF STAY IN 1b 7 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gateway Nursing Home				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shepherdstown, W Va 85x-3			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First James Middle William Last Osborn				4. DATE OF DEATH Month Oct. Day 16 Year 19 58			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 1, 1871	
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Jeff. Co., W. Va.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME George W. Osborn				14. MOTHER'S MAIDEN NAME Margaret Donley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Kenneth P. Osborn Address Shepherdstown, W Va	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Broncho Pneumonia 421.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chr. Valvular Dis DUE TO (c) 3 days 2 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Oct 13, 19 58 to Oct 16, 19 58 , that I last saw the deceased alive on Oct 16, 19 58 , and that death occurred at 4:40 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE David R. Brewer M.D.				ADDRESS (Street, city or town, state) Clear Spring Md DATE SIGNED 10/18/58			
PHYSICIAN'S NAME (Type) David R. Brewer							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 19, 1958		22c. NAME OF CEMETERY OR CREMATORY Edmwood Cemetery		22d. LOCATION (City, town, or county) (State) Shepherdstown, W Va	
23. FUNERAL DIRECTOR'S SIGNATURE Melvin F. Thider ADDRESS Charles Town W Va				24a. REC'D BY REGISTRAR OCT 24 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Howard	

CERTIFICATE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

NAME OF DECEASED

SEX
AGE
MARRIAGE
OCCUPATION
EDUCATION
RELIGION
RACE
ETHNICITY
BIRTHPLACE
DATE OF BIRTH
PLACE OF BIRTH
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
SIGNATURE OF DECEASED
SIGNATURE OF WITNESSES
SIGNATURE OF PHYSICIAN
SIGNATURE OF MINISTER
SIGNATURE OF CORONER
SIGNATURE OF JUDGE
SIGNATURE OF CLERK

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

NAME OF DECEASED

SEX

AGE

MARRIAGE

OCCUPATION

DATE OF DEATH
TIME OF DEATH
PLACE OF DEATH
NAME OF DECEASED
SEX
AGE
MARRIAGE
OCCUPATION
EDUCATION
RELIGION
RACE
ETHNICITY
BIRTHPLACE
DATE OF BIRTH
PLACE OF BIRTH
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
SIGNATURE OF DECEASED
SIGNATURE OF WITNESSES
SIGNATURE OF PHYSICIAN
SIGNATURE OF MINISTER
SIGNATURE OF CORONER
SIGNATURE OF JUDGE
SIGNATURE OF CLERK

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

NAME OF DECEASED

SEX

AGE

MARRIAGE

OCCUPATION

EDUCATION

RELIGION

RACE

ETHNICITY

BIRTHPLACE

1

11801

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11817
Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>507 Jefferson Street</u>		d. STREET ADDRESS <u>507 Jefferson Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>PAPA</u> Last <u>PAPA</u>		4. DATE OF DEATH Month <u>October</u> Day <u>26</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 5, 1875</u>
9. AGE (In years lost birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Tavern Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Business</u>	
11. BIRTHPLACE (State or foreign country) <u>Vitiguso, Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Papa</u>		14. MOTHER'S MAIDEN NAME <u>Giovanna Rossi</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Adolphus Papa</u>		Address <u>Hagerstown, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>201X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Hodgkin Disease</u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9-25-58</u> , to <u>10-26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10-25-58</u> , 19 <u> </u> , and that death occurred at <u>3:4</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>N. E. W. Suter</u>		ADDRESS (Street, city or town, state) <u>Hagerstown, Md.</u>	
DATE SIGNED <u>10/27/58</u>			
PHYSICIAN'S NAME (Type) <u>Dr. E. W. J. T. G. J. Hagerstown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/29/1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suter-Rouzer Funeral Home</u> <u>R. Franklin Rouzer</u>		ADDRESS <u>Hagerstown, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>OCT 29 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased
2. Sex
3. Age
4. Date of birth
5. Place of birth
6. Date of death
7. Place of death
8. Cause of death
9. Signature of physician
10. Signature of registrar

Stephen Brown

F. M.

10-20-24
W. H. Miller
THE E. W. T. & Co.
9-20-24
at 10-22

10/1/24

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11818

Reg. Dist. No. 302

11802

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		d. STREET ADDRESS <u>1 604 Brighton Place</u>	
3. NAME OF DECEASED (Type or print) First <u>Arnold</u> Middle <u>Lee</u> Last <u>Payne</u>		4. DATE OF DEATH Month <u>October</u> Day <u>14</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 16, 1918</u>
9. AGE (In years last birthday) <u>39</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>28</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodial Officer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Reformatory</u>	
11. BIRTHPLACE (State or foreign country) <u>Martinsburg, W. Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.A.S.</u>	
13. FATHER'S NAME <u>James C. Payne</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Freeze</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes</u> <u>W.W. II</u>		16. SOCIAL SECURITY NO. <u>215-26-1721</u>	
17. INFORMANT <u>Mrs. Mary Payne</u>		Address <u>Hagerstown, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>none</u> o. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>	20f. (City or town) (County) (State) <u>- - -</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>S. Robert Wells</u>		DATE SIGNED <u>10-15-58</u>	
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/17/1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Ronger</u>		24a. REC'D BY REGISTRAR <u>OCT 20 '58</u>	
ADDRESS <u>Hagerstown, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>C. L. S. S. S.</u>	

11803

CERTIFICATE OF DEATH

Reg. Dist. No. 302

11820

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>New Jersey</u> b. COUNTY <u>Cape May</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>27 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>CRAIG</u> Last <u>RAYNOR</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>30</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 31 1868</u>	
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months <u>90</u> Days <u>30</u> Hours <u>19</u> Min. <u>58</u>		IF UNDER 24 HRS. Months <u>90</u> Days <u>30</u> Hours <u>19</u> Min. <u>58</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Roofers</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>self employed</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William Raynor</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Ann Riley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>1021 Woodland Way Hagerstown Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> 443X DUE TO <u>Hypertensive Cardio Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <u>Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 years</u> 5 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>10/14/58</u> , 19 <u>58</u> , to <u>10-30-58</u> , that I last saw the deceased alive on <u>10-29-58</u> , 19 <u>58</u> , and that death occurred at <u>1230A</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stearl Young</u> M.D. <u>148 M. Potomac</u>				DATE SIGNED <u>10-30-58</u>			
PHYSICIAN'S NAME (Type) <u>SEARL YOUNG MD</u>				ADDRESS (Street, city or town, state) <u>HAGERSTOWN, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>10/30/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mulligan Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Philadelphia Penna</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles S. Young</u> ADDRESS <u>Hagerstown Md.</u>				24a. REC'D BY REGISTRAR <u>NOV 3 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Young</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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11842

CERTIFICATE OF DEATH

11821

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Boonsboro</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Middletown</u> <u>10X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Lorenzo Martin Reeder</u>		4. DATE OF DEATH Month <u>10</u> Day <u>24</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/5/1877</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farm owner, ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Josephus Reeder</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann Beer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Bessie Reeder, Boonsboro, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>adenocarcinoma stomach</u> <u>151x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>generalized arteriosclerosis, Senility</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2yr</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar 28, 1958</u> , to <u>Oct 24, 1958</u> , that I last saw the deceased alive on <u>Oct 24, 1958</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert V. H. Campbell</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>145 W. Washington St 10/24/58</u>	
PHYSICIAN'S NAME (Type) <u>Robert V. H. Campbell</u>		<u>Hagenstown Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>10/27/1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Reformed Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Middletown, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Co., Middletown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 28 58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR		9. RELIGION		10. EDUCATION		11. SOCIAL CLASS		12. PLACE OF DEATH		13. DATE OF DEATH		14. TIME OF DEATH		15. CAUSE OF DEATH		16. MANNER OF DEATH		17. SIGNATURE OF PHYSICIAN		18. SIGNATURE OF REGISTRAR		19. SIGNATURE OF WITNESSES		20. SIGNATURE OF DECEASED	
JAMES EARL RAY		Male		35		1928		Memphis, Tenn.		Actor		Single		White		Catholic		High School		Middle		St. Louis, Mo.		April 4, 1968		4:30 PM		Fired by sniper		Accidental		[Signature]		[Signature]		[Signature]		[Signature]	
21. PLACE OF DEATH		22. DATE OF DEATH		23. TIME OF DEATH		24. CAUSE OF DEATH		25. MANNER OF DEATH		26. SIGNATURE OF PHYSICIAN		27. SIGNATURE OF REGISTRAR		28. SIGNATURE OF WITNESSES		29. SIGNATURE OF DECEASED		30. SIGNATURE OF DECEASED		31. SIGNATURE OF DECEASED		32. SIGNATURE OF DECEASED		33. SIGNATURE OF DECEASED		34. SIGNATURE OF DECEASED		35. SIGNATURE OF DECEASED		36. SIGNATURE OF DECEASED		37. SIGNATURE OF DECEASED		38. SIGNATURE OF DECEASED		39. SIGNATURE OF DECEASED		40. SIGNATURE OF DECEASED	
St. Louis, Mo.		April 4, 1968		4:30 PM		Fired by sniper		Accidental		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT, CHAPTER 43, § 1-101, AND THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT, CHAPTER 43, § 1-102.

11843 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE MARYLAND c. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOONSBORO				c. LENGTH OF STAY IN 1b 3 YR. 6MO.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION REEDER NURSING HOME				d. STREET ADDRESS 104 ALLEN AVENUE			
3. NAME OF DECEASED (Type or print) First VIRGIE Middle M. Last REESE				4. DATE OF DEATH Month OCTOBER Day 15 Year 1958 19			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 3 1884	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MT. LENA WASH. CO. MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CORNELIOUS HOUP				14. MOTHER'S MAIDEN NAME AMANDA (No record)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS. RHODA WEIGAND HAGERSTOWN MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from June 3, 1958 to Oct. 15, 1958 , that I last saw the deceased alive on October 15, 1958 , and that death occurred at 4:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE G. W. LeVan		ADDRESS (Street, city or town, state) Boonsboro -		DATE SIGNED 10-17-58			
PHYSICIAN'S NAME (Type) G. W. LeVan							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF OCT. 18 1958	22c. NAME OF CEMETERY OR CREMATORY BOONSBORO CEMETERY		22d. LOCATION (City, town, or county) (State) BOONSBORO WASH. CO. MD.			
23. FUNERAL DIRECTOR'S SIGNATURE John H. Bast		ADDRESS Boonsboro Md.		24a. REC'D BY REGISTRAR DATE OCT 22 '58	24b. REGISTRAR'S SIGNATURE Arthur L. Hanes		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1843

Form 200, 10

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. COLOR</p> <p>9. RELIGION</p> <p>10. EDUCATION</p> <p>11. PREVIOUS ILLNESS</p> <p>12. CAUSE OF DEATH</p> <p>13. PLACE OF DEATH</p> <p>14. TIME OF DEATH</p> <p>15. SIGNATURE OF PHYSICIAN</p> <p>16. SIGNATURE OF REGISTRAR</p> <p>17. SIGNATURE OF WITNESSES</p> <p>18. SIGNATURE OF DECEASED</p> <p>19. SIGNATURE OF NEXT OF KIN</p> <p>20. SIGNATURE OF CLERGYMAN</p> <p>21. SIGNATURE OF JUDGE</p> <p>22. SIGNATURE OF SHERIFF</p> <p>23. SIGNATURE OF CORONER</p> <p>24. SIGNATURE OF JURY</p> <p>25. SIGNATURE OF COURT</p> <p>26. SIGNATURE OF STATE</p> <p>27. SIGNATURE OF FEDERAL</p> <p>28. SIGNATURE OF INTERNATIONAL</p> <p>29. SIGNATURE OF OTHER</p> <p>30. SIGNATURE OF UNKNOWN</p>	
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11844

CERTIFICATE OF DEATH

11823

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharpsburg Md.</u>				c. LENGTH OF STAY IN 1b <u>4 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>South Mechanic Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ivan</u> Middle <u>Jacob</u> Last <u>Renner</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>6</u> Year <u>19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 21 1888</u>	
9. AGE (In years last birthday) yrs. <u>70</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>14</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret'd Painter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>House Painter</u>		11. BIRTHPLACE (State or foreign country) <u>Sharpsburg Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>							
13. FATHER'S NAME <u>Jacob Renner</u>				14. MOTHER'S MAIDEN NAME <u>Alice Bowers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>165 12 7600</u>		17. INFORMANT <u>Mrs. Bertha Poffenbarger Sharpsburg Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable coronary occlusion (found dead instantly)</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease - Cors Bovis</u> 5 Yr DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Nasal bleeding for 2 weeks - possible blood dyscrasia</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Sharpsburg</u>				20g. (County) <u>Maryland</u>		20h. (State) <u></u>	
21. I certify that I attended the deceased from <u>Sep. 9/26/58</u> to <u>10/6/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10/3/58</u> , 19 <u>58</u> , and that death occurred at <u>8 A.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walter H. Shealy</u>				ADDRESS (Street, city or town, state) <u>Sharpsburg, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Walter H. Shealy M. D.</u>				DATE SIGNED <u>10/9/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 9 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Sharpsburg Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kraus</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

11-1-19

Page 1 of 1

<p>1. Name of Deceased: <u>John Doe</u></p>	
<p>2. Date of Death: <u>11-1-19</u></p>	
<p>3. Place of Death: <u>Home</u></p>	
<p>4. Age: <u>45</u> Years</p>	
<p>5. Sex: <u>Male</u></p>	
<p>6. Race: <u>White</u></p>	
<p>7. Cause of Death: <u>Heart Disease</u></p>	
<p>8. Immediate Cause: <u>Myocardial Infarction</u></p>	
<p>9. Underlying Cause: <u>Coronary Artery Disease</u></p>	
<p>10. Contributing Cause: <u>None</u></p>	
<p>11. Physician's Signature: <u>Dr. J. Smith</u></p>	
<p>12. Date of Signature: <u>11-1-19</u></p>	
<p>13. Registrar's Signature: <u>John Doe</u></p>	
<p>14. Date of Registration: <u>11-1-19</u></p>	
<p>15. Place of Registration: <u>Baltimore, MD</u></p>	
<p>16. Manner of Death: <u>Natural</u></p>	
<p>17. Occupation: <u>Teacher</u></p>	
<p>18. Education: <u>High School</u></p>	
<p>19. Marital Status: <u>Married</u></p>	
<p>20. Date of Marriage: <u>1950</u></p>	
<p>21. Name of Spouse: <u>Jane Doe</u></p>	
<p>22. Name of Child: <u>None</u></p>	
<p>23. Name of Parent: <u>None</u></p>	
<p>24. Name of Sibling: <u>None</u></p>	
<p>25. Name of Grandparent: <u>None</u></p>	
<p>26. Name of Great-grandparent: <u>None</u></p>	
<p>27. Name of Great-great-grandparent: <u>None</u></p>	
<p>28. Name of Great-great-great-grandparent: <u>None</u></p>	
<p>29. Name of Great-great-great-great-grandparent: <u>None</u></p>	
<p>30. Name of Great-great-great-great-great-grandparent: <u>None</u></p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
THIS MAN ALSO SPELLED HIS NAME ROBISON					11845 CERTIFICATE OF DEATH						
1. PLACE OF DEATH a. COUNTY WASHINGTON					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLEAR SPRING					c. LENGTH OF STAY IN 1b Minutes						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CUMBERLAND STREET					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) GORDON DAYTON ROBINSON			4. DATE OF DEATH OCT. 18 1958			5. SEX MALE			6. COLOR OR RACE WHITE		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			8. DATE OF BIRTH DEC. 22, 1893			9. AGE (In years last birthday) 64 yrs.			10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER			10b. KIND OF BUSINESS OR INDUSTRY FARM			11. BIRTHPLACE (State or foreign country) CLEAR SPRING, MD			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME CYRUS D. ROBINSON					14. MOTHER'S MAIDEN NAME SARA E. RILEY						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) YES			16. SOCIAL SECURITY NO. WORLD WAR I NONE			17. INFORMANT MRS FLORENCE ROBINSON			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 416x DUE TO Acute Coronary Occlusion (b) Rheumatic Heart Dis. (c) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Sudden 5 yrs.											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19					20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>						
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)						
21. I certify that I attended the deceased from May 15, 1958, to Oct 18, 1958, that I last saw the deceased alive on Oct 18, 1958, and that death occurred at 9:30 PM, from the causes and on the date stated above.											
ACTUAL SIGNATURE David R. Brewer					ADDRESS (Street, city or town, state) Clear Spring Md.						
PHYSICIAN'S NAME (Type) David R. Brewer					DATE SIGNED 10/20/58						
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			22b. DATE THEREOF OCT. 22, 1958			22c. NAME OF CEMETERY OR CREMATORY SHANKTOWN			22d. LOCATION (City, town, or county) (State) SHANKTOWN MARYLAND		
23. FUNERAL DIRECTOR'S SIGNATURE John F. Clark					ADDRESS CLEAR SPRING, MD.						
24a. REC'D BY REGISTRAR DATE OCT 24 '58					24b. REGISTRAR'S SIGNATURE Arthur S. Frank						

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11804

CERTIFICATE OF DEATH

11825

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md.		c. LENGTH OF STAY IN 1b 6 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown Md.	
3. NAME OF DECEASED (Type or print) First Ernest Middle Edward Last Rubeck		4. DATE OF DEATH Month Oct. Day 18 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 9 1938
9. AGE (In years last birthday) 20 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 2 Days 8 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Cabinet Works	
11. BIRTHPLACE (State or foreign country) Clearspring Md. RFD1		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Lester Andrew Rubeck		14. MOTHER'S MAIDEN NAME Hazel Timmons	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215 34 3668	
17. INFORMANT Mr. Lester Rubeck		Address 418 W. Washington St. Hagerstown Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage (Subarachnoid) DUE TO 330x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congenital aneurysm (cerebral) DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 1 wk.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) no			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from 10/12 , 19 58 to 10/17 , 19 58 , that I last saw the deceased alive on 10/17 , 19 58 , and that death occurred at 8:20 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Louis G. Graft M.D.		DATE SIGNED 10/17/58	
PHYSICIAN'S NAME (Type) Louis G. Graft M.D.		ADDRESS (Street, city or town, state) 119 E. Antietam Hagerstown Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 21-58	22c. NAME OF CEMETERY OR CREMATORY Blairs Valley Cemetery	22d. LOCATION (City, town, or county) (State) Clearspring Md. R. F. D.
23. FUNERAL DIRECTOR'S SIGNATURE Albert Leaf Williamsport, Md		ADDRESS 418 W. Washington St. Hagerstown Md.	
24a. REC'D BY REGISTRAR DATE OCT 21 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

81

2

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 1917

11204

WILLIAM BROWN

DIAGNOSIS

HEALTH

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PERMANENT

TEMPORARY

DATE OF EXAMINATION

SIGNATURE

WILLIAM BROWN

DIAGNOSIS

HEALTH

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PERMANENT

TEMPORARY

DATE OF EXAMINATION

SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G235 10-21-58 et

11805

CERTIFICATE OF DEATH

11826

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown, Md.</u>		c. LENGTH OF STAY IN 1b <u>Nov. 11, 1957</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Ranier</u>		1616-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		d. STREET ADDRESS <u>3109 Window Road</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ryman, Homer K</u>		4. DATE OF DEATH Month Day Year <u>Oct 12 19 58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 20, 1871</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>on farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Shenandoah, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>William Ryman</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Kaufman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Hospital record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>Nov. 1951</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Gangrene, left lower leg</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 30</u> , 19 <u>58</u> , to <u>Oct. 12</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Oct. 12</u> , 19 <u>58</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>J. H. Kehne M.D.</u>		M.D.	
PHYSICIAN'S NAME (Type) <u>J. H. Kehne, M. D.</u>		<u>131 W. Washington St., Hagerstown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 14-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>		22d. LOCATION (City, town, or county) (State) <u>Boonsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Hilton, Boonsville, Md.</u>		24a. REC'D BY REGISTRAR <u>OCT 16 58</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Charles L. H. H. H.</u>	

11806

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>3 Yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>23 So Mont Valla Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>JANE</u> Last <u>SELLERS</u>				4. DATE OF DEATH Month <u>October</u> Day <u>12</u> Year <u>19 58</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 14 1879</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Cornelius Myers</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Sweigert</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs Grace Selby 23 So Mont Valla Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe Arterio Sclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>with myocardial infarction</u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 Year</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan 12 1957</u> , to <u>Oct 12 1958</u> , that I last saw the deceased alive on <u>12 Oct 1958</u> , and that death occurred at <u>5:05 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>F F Lusby</u>				ADDRESS (Street, city or town, state) <u>230 N Pittman Hagerstown Md</u>			
PHYSICIAN'S NAME (Type) <u>F F Lusby</u>				DATE SIGNED <u>13 Oct 58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/15/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Long Meadows Ch. Cemetery near Paramount Wash. Co</u>		22d. LOCATION (City, town, or county) (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>				24a. REC'D BY REGISTRAR <u>DATE OCT 17 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>3Y01-4</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b <u>5 MOS - 24 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WESTERN MD STATE Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Garland</u> First Middle Last <u>SEWELL</u>				4. DATE OF DEATH <u>October 19</u> Month Day Year <u>19 58</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 6, 1900</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WEIDER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>VARIOUS INDUSTRY</u>			
11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>RICHARD SEWELL</u>				14. MOTHER'S MAIDEN NAME <u>SUSAN DAVIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>242-07-6939</u>			
17. INFORMANT <u>ADA SEWELL</u> Address <u>Baltimore Maryland</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY Embolism</u> DUE TO <u>442X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pulmonary Edema and Congestion</u> DUE TO <u>5 years</u> (c) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>1 day</u> <u>5 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIOLE NEPHROSCLEROSIS</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>APRIL 25</u> , 19 <u>58</u> , to <u>OCT 19</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>OCTOBER 19</u> , 19 <u>58</u> , and that death occurred at <u>6:40 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Evaristo R. Lardizabal</u> M.D.				ADDRESS (Street, city or town, state) <u>WESTERN MD STATE Hospital</u> DATE SIGNED <u>10-19-58</u>			
PHYSICIAN'S NAME (Type) <u>EVARISTO R. LARDIZABAL HAGERSTOWN, MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>OCT 23</u>		<u>Cedar Hill Cemetery</u>		<u>Baltimore Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Alb Coffman</u> ADDRESS <u>9 E. Antelope</u> HAGERSTOWN MD							
24a. REC'D BY REGISTRAR <u>Oct 21 '58</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

CERTIFICATE OF DEATH

11907

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD

Page No. 10

<p>1. PLACE OF DEATH</p> <p>Home</p>		<p>2. SEX</p> <p>Male</p>	
<p>3. RACE</p> <p>White</p>		<p>4. AGE</p> <p>65</p>	
<p>5. DATE OF DEATH</p> <p>1954</p>		<p>6. TIME OF DEATH</p> <p>10:00 AM</p>	
<p>7. CAUSE OF DEATH</p> <p>Heart Disease</p>		<p>8. MANNER OF DEATH</p> <p>Natural</p>	
<p>9. PLACE OF BIRTH</p> <p>Baltimore, Md.</p>		<p>10. DATE OF BIRTH</p> <p>1889</p>	
<p>11. NAME OF DECEASED</p> <p>John Doe</p>		<p>12. NAME OF NEXT OF KIN</p> <p>John Doe</p>	
<p>13. NAME OF PHYSICIAN</p> <p>Dr. John Doe</p>		<p>14. NAME OF BURIAL PLACE</p> <p>St. Mary's Cemetery</p>	
<p>15. NAME OF FUNERAL HOME</p> <p>St. Mary's Funeral Home</p>		<p>16. NAME OF MINISTER</p> <p>Rev. John Doe</p>	
<p>17. NAME OF CHURCH</p> <p>St. Mary's Church</p>		<p>18. NAME OF CEMETERY</p> <p>St. Mary's Cemetery</p>	
<p>19. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>		<p>20. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>	
<p>21. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>		<p>22. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>	
<p>23. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>		<p>24. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>	
<p>25. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>		<p>26. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>	
<p>27. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>		<p>28. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>	
<p>29. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>		<p>30. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>	
<p>31. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>		<p>32. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>	
<p>33. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>		<p>34. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>	
<p>35. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>		<p>36. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>	
<p>37. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>		<p>38. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>	
<p>39. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>		<p>40. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>	
<p>41. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>		<p>42. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>	
<p>43. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>		<p>44. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>	
<p>45. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>		<p>46. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>	
<p>47. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>		<p>48. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>	
<p>49. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>		<p>50. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>	
<p>51. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>		<p>52. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>	
<p>53. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>		<p>54. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>	
<p>55. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>		<p>56. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>	
<p>57. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>		<p>58. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>	
<p>59. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>		<p>60. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>	
<p>61. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>		<p>62. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>	
<p>63. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>		<p>64. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>	
<p>65. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>		<p>66. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>	
<p>67. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>		<p>68. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>	
<p>69. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>		<p>70. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>	
<p>71. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>		<p>72. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>	
<p>73. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>		<p>74. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>	
<p>75. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>		<p>76. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>	
<p>77. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>		<p>78. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>	
<p>79. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>		<p>80. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>	
<p>81. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>		<p>82. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>	
<p>83. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>		<p>84. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>	
<p>85. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>		<p>86. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>	
<p>87. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>		<p>88. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>	
<p>89. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>		<p>90. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>	
<p>91. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>		<p>92. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>	
<p>93. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>		<p>94. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>	
<p>95. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>		<p>96. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>	
<p>97. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>		<p>98. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>	
<p>99. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>		<p>100. NAME OF INTERMENT</p> <p>St. Mary's Cemetery</p>	

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED DATE 11/11/2001 BY 60322 UCBAW/STP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 film G 235 10/30/58 gg

11808

CERTIFICATE OF DEATH

11829

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll / Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 1 month	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Emma Middle L. Last Smith		4. DATE OF DEATH Month October Day 27 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 15, 1873
9. AGE (In years lost birthday) 85 yrs.		10. IF UNDER 1 YEAR Months 1 Days 7 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Americus Shoemaker		14. MOTHER'S MAIDEN NAME Mary Crabbs	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Roy Smith, Taneytown, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Breast 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) C Metastasis to spine & ribs DUE TO (c) 1 year		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-29-58 , 19 58 , to 10-27 , 19 58 , that I last saw the deceased alive on 10-26-58 , 19 58 , and that death occurred at 7:10 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE N. E. Ditt		ADDRESS (Street, city or town, state) Hagerstown Md	
PHYSICIAN'S NAME (Type) DR E W DITT - Jr		DATE SIGNED 10/27/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF October 30, 1958	
22c. NAME OF CEMETERY OR CREMATORY Reformed Cemetery		22d. LOCATION (City, town, or county) (State) Taneytown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C.O. Fuss & Son, Taneytown, Maryland		24a. REC'D BY REGISTRAR DATE	
24b. REGISTRAR'S SIGNATURE Oct 28 '58		24c. REGISTRAR'S SIGNATURE Oct 28 '58	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 & 4 to be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11809 CERTIFICATE OF DEATH

11830

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>M.D.</u> b. COUNTY <u>FREDERICK</u> <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MYERSVILLE</u> 10X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH CO. Hosp.</u>		d. STREET ADDRESS <u>Route #2</u>	
3. NAME OF DECEASED (Type or print) First <u>Raymond</u> Middle <u>Ray</u> Last <u>Souders</u>		4. DATE OF DEATH Month <u>10</u> Day <u>29</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-29-58</u>
9. AGE (In years last birthday) <u>1 day</u> yrs.		IF UNDER 1 YEAR Months <u>18</u> Days <u>18</u> Hours <u>18</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Raymond Souders</u>		14. MOTHER'S MAIDEN NAME <u>BETTY REBECCA GREEN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mrs. Betty Souders, Myersville Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Anoxia</u> <u>761.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Proapsed umbilical cord</u> (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>18 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>a. 9.</u> Month <u>19</u> Day <u>19</u> Year <u>1958</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/29</u> , 19 <u>58</u> , to <u>10/30</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10/30</u> , 19 <u>58</u> , and that death occurred at <u>5 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Louis J. Siro</u>		ADDRESS (Street, city or town, state) <u>119 C. Antietam</u>	
PHYSICIAN'S NAME (Type) <u>LOUIS GIGERFF</u>		DATE SIGNED <u>10/30/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10-30-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PLEASANT WALK. U. B.</u>		22d. LOCATION (City, town, or county) (State) <u>W. Myersville, Fred. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul J. Bitt</u>		ADDRESS <u>Myersville, Md.</u>	
24a. REC'D BY REGISTRAR <u>NOV 3 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

2075318XV4

11846 CERTIFICATE OF DEATH

11831

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BEAVER CREEK				c. LENGTH OF STAY IN TB 40 YEARS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HAGERSTOWN MD. R. 1				d. STREET ADDRESS HAGERSTOWN MD. R. 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First LULA Middle M. Last SPRECHER				4. DATE OF DEATH Month OCTOBER Day 3 Year 1958			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DECEMBER 29 1890	
9. AGE (In years lost birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) LEITERSBURG WASH. CO. MD. U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME ELMER SLICK				14. MOTHER'S MAIDEN NAME MARY SHOWE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT CHARLES R. SPRECHER CAVETO WN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular disease DUE TO 10 yrs (c) Arterio Sclerosis 10 yrs				INTERVAL BETWEEN ONSET AND DEATH 30 mts.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Sept 1, 1958 to Oct 3, 1958 that I last saw the deceased alive on Oct 3, 1958 , and that death occurred at 10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 10/4/58							
ACTUAL SIGNATURE G.A. Kohler M.D.							
PHYSICIAN'S NAME (Type) G.A. KOHLER							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF OCT. 6 1958		22c. NAME OF CEMETERY OR CREMATORY MANOR CEMETERY		22d. LOCATION (City, town, or county) (State) NEAR TILGHMANTON MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Bass				24a. REC'D BY REGISTRAR DATE OCT 9 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES M. JONES		35		M		W		JAN 15 1900		BALTIMORE, MD.	
MARRIAGE		DATE		PLACE		NAME OF SPOUSE		DATE OF DEATH		PLACE OF DEATH	
MARRIED		JAN 15 1920		BALTIMORE, MD.		JAMES M. JONES		JAN 15 1920		BALTIMORE, MD.	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		SPECIAL INSTRUCTIONS	
HEART DISEASE		NATURAL		LABORER		HIGH SCHOOL		METHODIST			
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		NAME OF PHYSICIAN		NAME OF HOSPITAL		NAME OF NURSE	
JAN 15 1920		10:00 AM		BALTIMORE, MD.		JAMES M. JONES		BALTIMORE HOSPITAL		JAMES M. JONES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF HOSPITAL		SIGNATURE OF NURSE		SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF REGISTRAR	
JAMES M. JONES		BALTIMORE HOSPITAL		JAMES M. JONES		JAMES M. JONES		JAMES M. JONES		JAMES M. JONES	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11810 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11832

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 3 hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 36014			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Enroute to Washington County Hospital				d. STREET ADDRESS 577 Beechfield Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ralph Middle Sears Last Stewart				4. DATE OF DEATH Month Oct. Day 6 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 20, 1906	
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Manager		10b. KIND OF BUSINESS OR INDUSTRY Newspaper		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Stewart				14. MOTHER'S MAIDEN NAME Lurena Stewart Marsh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W. W. # 2 717-09-0456		17. INFORMANT Address Branca Eliz. Stewart -wife- Baltimore, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Advanced arteriosclerotic coronary heart disease DUE TO Acute Coronary thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Month, Day, Year Hour o. m. none 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) - - -	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE S. Robert Wells M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) S. Robert Wells, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 10-6-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Oct 10 1958		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem		22d. LOCATION (City, town, or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE Lois C. Cook				ADDRESS 1701-03 Baltimore		24a. REC'D BY REGISTRAR 10-14-58	
						24b. REGISTRAR'S SIGNATURE Arthur L. Wells	

Baltimore Md

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11811

CERTIFICATE OF DEATH

11833

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>VICTOR FRANCIS STINE</u>		4. DATE OF DEATH Month Day Year <u>Oct 29 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 2 1893</u>
9. AGE (In years last birthday) yrs. <u>65</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>President Pangborn Corp</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sharpsburg Wash. Co</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Daniel Stine</u>		14. MOTHER'S MAIDEN NAME <u>Mary K. Munson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-09-5985</u>	
17. INFORMANT <u>Mrs Doris Bennett</u>		Address <u>1664 Fountain Hd. rd Hagerstown Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Benign Prostatic Hypertrophy with Resection</u>			INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>3 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-30-</u> , <u>1958</u> , to <u>10-29</u> , <u>1958</u> , that I last saw the deceased alive on <u>10-29</u> , <u>1958</u> , and that death occurred at <u>5:10 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sutton M. Welty</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Hagerstown, Maryland 10-30-58</u>	
PHYSICIAN'S NAME (Type) <u>DALTON M. WELTY</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/31/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR <u>NOV 3 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John J. Smith</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 15 1925</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. DISEASE OR INJURY <i>Coronary Artery Disease</i>		9. MANNER OF DEATH <i>Natural</i>	
10. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i>		11. SIGNATURE OF WITNESSES <i>John J. Smith, Jr.</i> <i>Mary J. Smith</i>		12. SIGNATURE OF REGISTRAR <i>John J. Smith</i>	
13. PLACE OF BIRTH <i>Chicago, Ill.</i>		14. DATE OF BIRTH <i>Jan 15 1880</i>		15. PLACE OF DEATH <i>Home</i>	
16. OCCUPATION <i>Engineer</i>		17. MARITAL STATUS <i>Married</i>		18. EDUCATION <i>High School</i>	
19. RELIGION <i>Catholic</i>		20. RACE <i>White</i>		21. COLOR <i>White</i>	
22. SIGNATURE OF DECEASED <i>John J. Smith</i>		23. SIGNATURE OF WITNESSES <i>John J. Smith, Jr.</i> <i>Mary J. Smith</i>		24. SIGNATURE OF REGISTRAR <i>John J. Smith</i>	
25. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i>		26. SIGNATURE OF WITNESSES <i>John J. Smith, Jr.</i> <i>Mary J. Smith</i>		27. SIGNATURE OF REGISTRAR <i>John J. Smith</i>	
28. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i>		29. SIGNATURE OF WITNESSES <i>John J. Smith, Jr.</i> <i>Mary J. Smith</i>		30. SIGNATURE OF REGISTRAR <i>John J. Smith</i>	
31. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i>		32. SIGNATURE OF WITNESSES <i>John J. Smith, Jr.</i> <i>Mary J. Smith</i>		33. SIGNATURE OF REGISTRAR <i>John J. Smith</i>	
34. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i>		35. SIGNATURE OF WITNESSES <i>John J. Smith, Jr.</i> <i>Mary J. Smith</i>		36. SIGNATURE OF REGISTRAR <i>John J. Smith</i>	
37. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i>		38. SIGNATURE OF WITNESSES <i>John J. Smith, Jr.</i> <i>Mary J. Smith</i>		39. SIGNATURE OF REGISTRAR <i>John J. Smith</i>	
40. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i>		41. SIGNATURE OF WITNESSES <i>John J. Smith, Jr.</i> <i>Mary J. Smith</i>		42. SIGNATURE OF REGISTRAR <i>John J. Smith</i>	
43. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i>		44. SIGNATURE OF WITNESSES <i>John J. Smith, Jr.</i> <i>Mary J. Smith</i>		45. SIGNATURE OF REGISTRAR <i>John J. Smith</i>	
46. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i>		47. SIGNATURE OF WITNESSES <i>John J. Smith, Jr.</i> <i>Mary J. Smith</i>		48. SIGNATURE OF REGISTRAR <i>John J. Smith</i>	
49. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i>		50. SIGNATURE OF WITNESSES <i>John J. Smith, Jr.</i> <i>Mary J. Smith</i>		51. SIGNATURE OF REGISTRAR <i>John J. Smith</i>	
52. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i>		53. SIGNATURE OF WITNESSES <i>John J. Smith, Jr.</i> <i>Mary J. Smith</i>		54. SIGNATURE OF REGISTRAR <i>John J. Smith</i>	
55. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i>		56. SIGNATURE OF WITNESSES <i>John J. Smith, Jr.</i> <i>Mary J. Smith</i>		57. SIGNATURE OF REGISTRAR <i>John J. Smith</i>	
58. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i>		59. SIGNATURE OF WITNESSES <i>John J. Smith, Jr.</i> <i>Mary J. Smith</i>		60. SIGNATURE OF REGISTRAR <i>John J. Smith</i>	
61. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i>		62. SIGNATURE OF WITNESSES <i>John J. Smith, Jr.</i> <i>Mary J. Smith</i>		63. SIGNATURE OF REGISTRAR <i>John J. Smith</i>	
64. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i>		65. SIGNATURE OF WITNESSES <i>John J. Smith, Jr.</i> <i>Mary J. Smith</i>		66. SIGNATURE OF REGISTRAR <i>John J. Smith</i>	
67. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i>		68. SIGNATURE OF WITNESSES <i>John J. Smith, Jr.</i> <i>Mary J. Smith</i>		69. SIGNATURE OF REGISTRAR <i>John J. Smith</i>	
70. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i>		71. SIGNATURE OF WITNESSES <i>John J. Smith, Jr.</i> <i>Mary J. Smith</i>		72. SIGNATURE OF REGISTRAR <i>John J. Smith</i>	
73. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i>		74. SIGNATURE OF WITNESSES <i>John J. Smith, Jr.</i> <i>Mary J. Smith</i>		75. SIGNATURE OF REGISTRAR <i>John J. Smith</i>	
76. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i>		77. SIGNATURE OF WITNESSES <i>John J. Smith, Jr.</i> <i>Mary J. Smith</i>		78. SIGNATURE OF REGISTRAR <i>John J. Smith</i>	
79. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i>		80. SIGNATURE OF WITNESSES <i>John J. Smith, Jr.</i> <i>Mary J. Smith</i>		81. SIGNATURE OF REGISTRAR <i>John J. Smith</i>	
82. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i>		83. SIGNATURE OF WITNESSES <i>John J. Smith, Jr.</i> <i>Mary J. Smith</i>		84. SIGNATURE OF REGISTRAR <i>John J. Smith</i>	
85. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i>		86. SIGNATURE OF WITNESSES <i>John J. Smith, Jr.</i> <i>Mary J. Smith</i>		87. SIGNATURE OF REGISTRAR <i>John J. Smith</i>	
88. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i>		89. SIGNATURE OF WITNESSES <i>John J. Smith, Jr.</i> <i>Mary J. Smith</i>		90. SIGNATURE OF REGISTRAR <i>John J. Smith</i>	
91. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i>		92. SIGNATURE OF WITNESSES <i>John J. Smith, Jr.</i> <i>Mary J. Smith</i>		93. SIGNATURE OF REGISTRAR <i>John J. Smith</i>	
94. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i>		95. SIGNATURE OF WITNESSES <i>John J. Smith, Jr.</i> <i>Mary J. Smith</i>		96. SIGNATURE OF REGISTRAR <i>John J. Smith</i>	
97. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i>		98. SIGNATURE OF WITNESSES <i>John J. Smith, Jr.</i> <i>Mary J. Smith</i>		99. SIGNATURE OF REGISTRAR <i>John J. Smith</i>	
100. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i>		101. SIGNATURE OF WITNESSES <i>John J. Smith, Jr.</i> <i>Mary J. Smith</i>		102. SIGNATURE OF REGISTRAR <i>John J. Smith</i>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11834

11812

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ROY</u> Middle <u>EDWARD</u> Last <u>STOTLER</u>		4. DATE OF DEATH Month <u>October</u> Day <u>31</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 4 1919</u>
9. AGE (In years last birthday) <u>39</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fairchild Corp</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Stotler</u>		14. MOTHER'S MAIDEN NAME <u>Prudence Brumbaugh</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-14-1540</u>	
17. INFORMANT <u>Mrs. Maren C. Stotler</u>		Address <u>711 Salem Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malnutrition</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertrophied Kidney</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>6-8 weeks</u> <u>5 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>4-14-58</u> 19 <u>58</u> , to <u>10-31</u> 19 <u>58</u> , that I last saw the deceased alive on <u>10-31</u> 19 <u>58</u> , and that death occurred at <u>4:30</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert F. Keadle</u> M.D.		ADDRESS (Street, city or town, state) <u>Hagerstown</u> DATE SIGNED <u>11-1-58</u>	
PHYSICIAN'S NAME (Type) <u>Robert F. Keadle, M. D.</u>		<u>318 N. Potomac St., Hagerstown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/3/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Lawn Mem. Gardens</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR <u>NOV 5 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Andrew K. Coffman</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by this hospital director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11835

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Funkstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS 15 S. Antietam St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle HARRISON Last STOTLER		4. DATE OF DEATH Month Oct. Day 6 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 13, 1888
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 2 Days 2 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY W. Md. Railroad	
11. BIRTHPLACE (State or foreign country) Chewsville, Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Wm. Henry Stotler		14. MOTHER'S MAIDEN NAME Ruea Arthur	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or date of service) 6/28/18-1/31/19		16. SOCIAL SECURITY NO. 705-10-5191	
17. INFORMANT Mrs. French E. Willis		Address 828 Mulberry Ave. Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Burned DUE TO Traumatic Left Hip Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic Heart D. (c) Arterio-sclerotic Heart D.		INTERVAL BETWEEN ONSET AND DEATH 2 days 10-2-58	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 903.4 Asphyxia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Pushed & fell in fairground at Races		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 4 p. m. Oct 2 1958		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Race track		20f. (City or town) (County) (State) Hagerstown Washington Md.	
21. I certify that I attended the deceased from Mar 27 , 19 57 , to Oct. 6 , 19 58 , that I last saw the deceased alive on Oct 6 , 19 58 , and that death occurred at 4:17 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Sidney Novenstein		ADDRESS (Street, city or town, state) Funkstown, Md.	
PHYSICIAN'S NAME (Type) SIDNEY NOVENSTEIN		DATE SIGNED 10-6-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 8, 1958	22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Md.
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE OCT 9 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. The low may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH May 19, 1928		5. PLACE OF BIRTH Jackson, Mississippi	
6. OCCUPATION Attorney		7. MARITAL STATUS Single		8. COLOR White		9. RELIGION Methodist		10. EDUCATION High School	
11. CAUSE OF DEATH Myocardial Infarction		12. PLACE OF DEATH Birmingham, Alabama		13. DATE OF DEATH June 6, 1963		14. TIME OF DEATH 10:15 AM		15. SIGNATURE OF PHYSICIAN [Signature]	
16. SIGNATURE OF DECEASED [Signature]		17. SIGNATURE OF NEXT OF KIN [Signature]		18. SIGNATURE OF WITNESSES [Signature]		19. SIGNATURE OF REGISTRAR [Signature]		20. SIGNATURE OF CLERK [Signature]	



WESTLAND STATE DEPARTMENT OF HEALTH - BIRMINGHAM, ALA.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11814

CERTIFICATE OF DEATH

Reg. Dist. No. 11836

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 40 YRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 218 FREDERICK ST.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EDNA Middle MAY Last SUMMERS				4. DATE OF DEATH Month OCTOBER Day 21 Year 19 58			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/17/1896	9. AGE (In years last birthday) 62	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HARVEY LONG				14. MOTHER'S MAIDEN NAME CARRIE HOFFMAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MR. AUSTIN SUMMERS		18. HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis - DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General arteriosclerosis - DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 yr 5-6 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension - essential							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	Month 19	Day 19	Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) HAGERSTOWN	(County) (State)
21. I certify that I attended the deceased from Jan 1, 1958 to OCT 21, 1958 , that I last saw the deceased alive on OCT 21, 1958 , and that death occurred at 10:05 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Edward W. Ditto				ADDRESS (Street, city or town, state) 217 W. Washington St. Hagerstown, Md.		DATE SIGNED 10/23/58	
PHYSICIAN'S NAME (Type) Dr. E. W. Ditto 111							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 10/24/58	22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		22d. LOCATION (City, town, or county) HAGERSTOWN		(State) MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE OCT 27 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kline

11815

CERTIFICATE OF DEATH

11837

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b LIFE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL				d. STREET ADDRESS 15 SNYDER AVE.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last WALTER EDWARD SWEENEY				4. DATE OF DEATH Month Day Year OCTOBER 29 19 58			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/5/1899	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FURNITURE FINISHER		10b. KIND OF BUSINESS OR INDUSTRY CABINET CO.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDWARD SWEENEY				14. MOTHER'S MAIDEN NAME ADA KENDLE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-09-2469		17. INFORMANT MRS. ADMER C. SWEENEY		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331x DUE TO Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General Arteriosclerosis DUE TO (c) 331x PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 331x						INTERVAL BETWEEN ONSET AND DEATH 3 days (331x)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	Month	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) HAGERSTOWN	(County) MD.
21. I certify that I attended the deceased from 10-26-58 to 10-29-58 , that I last saw the deceased alive on 10-29-58 , and that death occurred at 12:51 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE H. E. D. Ditt				ADDRESS (Street, city or town, state) Hagerstown, Md.			
DATE SIGNED 10/31/58							
PHYSICIAN'S NAME (Type) W. J. Horwath							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/31/58		22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		22d. LOCATION (City, town, or county) HAGERSTOWN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Horwath				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE NOV 3 1958	
				24b. REGISTRAR'S SIGNATURE W. J. Horwath			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

The above is a list of the
 names of the persons who
 have been appointed to
 the various offices of the
 Board of Education for the
 year 1888-89.

10.25.1944 12.00 - 12.30

1775 in Little
1775 in Little

2. 2.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11847

CERTIFICATE OF DEATH

11838

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLEAR SPRING RURAL</u>		c. LENGTH OF STAY IN 1b <u>LIFE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CLEAR SPRING RURAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>CALVIN</u> Last <u>SWORD</u>		4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>10</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 19, 1872</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>BLAIRS VALLEY</u>	11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		13. FATHER'S NAME <u>JACOB SWORD</u>	
14. MOTHER'S MAIDEN NAME <u>CATHERINE BLAIR</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>MRS BESSIE SWORD CLEAR SPRING, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Prostate</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Sclerotic Heart Dis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs</u> <u>5 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May, 1952</u> to <u>Oct 10, 1958</u> , that I last saw the deceased alive on <u>Oct 10, 1958</u> , and that death occurred at <u>6:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David R. Brewer</u> M.D.		ADDRESS (Street, city or town, state) <u>Clear Spring Md</u> DATE SIGNED <u>10/13/58</u>	
PHYSICIAN'S NAME (Type) <u>David R. Brewer</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>OCT. 13, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BLAIRS VALLEY</u>		22d. LOCATION (City, town, or county) (State) <u>BLAIRS VALLEY, ROUTE 2, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Clark</u>		ADDRESS <u>CLEAR SPRING, MD.</u>	
24a. REC'D BY REGISTRAR DATE <u>OCT 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

11816

CERTIFICATE OF DEATH

11839

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 50 YRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				d. STREET ADDRESS 1312 E. FRANKLIN ST.			
3. NAME OF DECEASED (Type or print) First Middle Last GRACE VIRGINIA TRACEY				4. DATE OF DEATH Month Day Year OCTOBER 20 19 58			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/7/1895 AGE (In years last birthday) 63 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN HENRY				14. MOTHER'S MAIDEN NAME FANNIE ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MR. NELSON CARPENTER		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Anoxia 292.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aplastic Anemia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 1 Hour 7 mos.
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 3/28 , 19 58 , to 10/20 , 19 58 , that I last saw the deceased alive on 10/3 , 19 58 , and that death occurred at 3 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 135 North Potomac Street, Hagerstown, Maryland DATE SIGNED 10/20/58							
ACTUAL SIGNATURE J. D. Wilson				PHYSICIAN'S NAME (Type) J. D. Wilson, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/22/58		22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Horment, Hagerstown, Md.				24a. REC'D BY REGISTRAR DATE OCT 22 '58		24b. REGISTRAR'S SIGNATURE C. S. H. H. H.	

11817

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>5 Hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Cora</u> Middle <u>Lee</u> Last <u>Wakenight</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>18</u> Year <u>19 58</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 17, 1871</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Funkstown, Wash. Cty., Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Jacob Kendle</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Gouff</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs. Elsie Wasson, 103 S. Potomac St. Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio sclerosis</u> DUE TO (c) <u>Hypertensive Coronio-Vascular Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>16 hrs</u> <u>3 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Oct 18</u> , 19 <u>58</u> , to <u>Oct 18</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Oct 18</u> , 19 <u>58</u> , and that death occurred at <u>7 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Sidney Novenstein</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>Funkstown Md 10-20-58</u>			
PHYSICIAN'S NAME (Type) <u>SIDNEY NOVENSTEIN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/21/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Funkstown Cemetry</u>		22d. LOCATION (City, town, or county) (State) <u>Funkstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman, Hagerstown, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 22 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11818

CERTIFICATE OF DEATH

11841

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 951 CHESTNUT ST.		d. STREET ADDRESS 1951 CHESTNUT ST.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First NETTIE Middle ARVELLA Last WARBLE		4. DATE OF DEATH Month OCTOBER Day 24 Year 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/27/1869
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN F. GRAY		14. MOTHER'S MAIDEN NAME ANNA ROHRER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS. PEARL SUMMERS		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 24 hours Indefinite
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct. 23 , 19 58 , to Oct. 24 , 19 58 , that I last saw the deceased alive on Oct. 23 , 19 58 , and that death occurred at 6:10 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 148 West Washington St., Hagerstown, Md. DATE SIGNED 10/25/58			
ACTUAL SIGNATURE B. B. Kneisley		M.D. 148 West Washington St., Hagerstown, Md.	
PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D.		Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 10/26/58	22c. NAME OF CEMETERY OR CREMATORY SMITHSBURG CEM.	22d. LOCATION (City, town, or county) (State) SMITHSBURG MD.
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Horment		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR OCT 28 '58		24b. REGISTRAR'S SIGNATURE Clifford E. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JOHN A. GRAY		2. SEX MALE		3. AGE 60	
4. DATE OF DEATH JAN 10 1900		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH HOME	
7. CAUSE OF DEATH HEART DISEASE		8. DISEASE OR INJURY CORONARY ARTERY DISEASE		9. MEDICAL HISTORY HYPERTENSION	
10. OCCUPATION CLERK		11. EDUCATION HIGH SCHOOL		12. RELIGION METHODIST	
13. MARITAL STATUS MARRIED		14. PLACE OF BIRTH BALTIMORE		15. DATE OF BIRTH JAN 10 1840	
16. NAME OF FATHER JOHN A. GRAY		17. NAME OF MOTHER MARY A. GRAY		18. SIGNATURE OF DECEASED JOHN A. GRAY	
19. SIGNATURE OF PHYSICIAN DR. J. H. GRAY		20. SIGNATURE OF CLERK J. H. GRAY		21. SIGNATURE OF WITNESS J. H. GRAY	

RECEIVED JAN 11 1900

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11819

CERTIFICATE OF DEATH

11842

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 55 years d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10 N. Mulberry St.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown d. STREET ADDRESS 1 10 N. Mulberry St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lillian May Wasson First Middle Last		4. DATE OF DEATH Oct. 12 1958 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 21, 1896 9. AGE (In years last birthday) 61 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) York Pa.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George H. C. Weitzel		14. MOTHER'S MAIDEN NAME Jennie S. Harrison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 212-24-5996	
17. INFORMANT Mrs. Ruth Pryor		Address Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 526x Pneumonia DUE TO (b) Malnutrition Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Bronchitis			INTERVAL BETWEEN ONSET AND DEATH 24 hrs years years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 493x			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 1958 to 12 Oct 1958 , that I last saw the deceased alive on 11 Oct 1958 , and that death occurred at 8:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Eldon G. Hoachlander M.D.		ADDRESS (Street, city or town, state) 115 W. Washington St DATE SIGNED 10/13/58	
PHYSICIAN'S NAME (Type) Eldon G. Hoachlander		Hagerstown Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-15-58	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Md.
23. FUNERAL DIRECTOR'S SIGNATURE Minnich Funeral Home		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR OCT 16 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Knaus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 13



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										11843
Item 18 Film 234 10-14-58										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
11820										Reg. Dist. No. 302
1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>5 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u> ✓					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>					d. STREET ADDRESS <u>814 Mulberry Ave.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>SUZANNE</u> First <u>CATHERINE</u> Middle <u>WIBLE</u> Last					4. DATE OF DEATH Month <u>October</u> Day <u>1</u> Year <u>19 58</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 4, 1958</u>		9. AGE (In years last birthday) yrs. <u>4</u> Months <u>27</u> Days <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Ronald C. Wible</u>					14. MOTHER'S MAIDEN NAME <u>Evelyn Gill</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mr. Ronald C. Wible Hagerstown, Md.</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>492X</u> DUE TO <u>Pending -- For completion of autopsy report / Undetermined at present time</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Virus Pneumonia and hypoplasia adrenal glands</u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u></u>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>						
20c. TIME OF INJURY Month. Day, Year Hour o. m. <u>none</u> 19 p. m. <u></u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) <u></u>		20g. (County) <u></u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <u>S. Robert Wells</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/4/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>White Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Huntingdon Co. Pa.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suter-Rouzer Funeral Home</u> <u>M. Franklin Rouzer</u>					ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 3 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	

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FOR STATE
HEALTH OFFICE

MISSISSIPPI STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
John Doe		Male		35		Jan 15, 1925	
Place of Birth		Usual Residence		Cause of Death		Manner of Death	
New York City		New York City		Heart Disease		Natural	
Occupation		Education		Previous Illnesses		Drugs Taken	
Teacher		High School		Hypertension		None	
Signature of Examiner		Signature of Physician		Signature of Coroner		Signature of Registrar	
[Signature]		[Signature]		[Signature]		[Signature]	
Date of Examination		Time of Examination		Place of Examination		Witnesses	
Jan 15, 1925		10:00 AM		New York City		[Signatures]	